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Help Kids Talk – a community-wide initiative that aims to give every child the best start in life by prioritising speech, language and communication development

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Description

Help Kids Talk is a project within Early Intervention Lisburn (EIL) which is led by the Resurgam Community Development Trust (lead partners are the South Eastern Health and Social Care Trust (SEHSCT) Speech and Language Therapy Team and Early Intervention Lisburn).

The Help Kids Talk vision is that “everyone will work together to help kids talk”.

The project is a community-wide initiative and aims to ensure everyone who has any responsibility for a child prioritises speech, language and communication development whether you are a parent, grandparent, childminder or work in an organisation that provides services for children.

By prioritising early intervention and speech, language and communication, there will be a positive impact across all areas of a child’s life including: educational attainment, mental health and wellbeing, social relationships and employability later in life.

Context

Help Kids Talk aims to give every child the best chance in life by prioritising speech, language and communication development.

The purpose of Help Kids Talk is to:

- help children and young people to be the best they can be
- make it everyone’s responsibility
- make a difference together

Main priorities are:

- Highlighting options of support
- Working together

- Learning for all
- Improving the quality of services

Help Kids Talk was co-designed following the extensive research report ‘the Best for Every Child’ (Courtney, 2012) which highlighted the issues children and young people faced growing up in Lisburn. At that time, 74% of young people were leaving the post primary sector (excluding Wallace and Friends) without 5+ GCSEs (including English and Maths). In 2013, a prevalence study carried out by the SEHSCT Speech and Language Therapy team indicated that 32% of children entering primary one in 9 schools in Lisburn had a mild to severe speech, language, and communication problem, of which, 74% were boys from disadvantaged areas (Jordan & Coulter, 2016).

Method

There are 4 main strands to Help Kids Talk:

1. 12 key messages were developed to support speech, language and communication. The ‘message of the month’ is circulated via email and social media as guidance to parents, caregivers and those working with children.

2. Basic Awareness Training was developed and is delivered on a monthly basis online. This aims to raise awareness of the importance of speech, language and communication for everyone who has any responsibility for a child. In the Basic Awareness, the 12 key messages are linked with Kate Cairns Associates five to thrive building blocks to highlight the connection between infant mental health, brain development and communication development. Further training is in the process of being co-designed and co-produced.

3. The ICAN (Speech and Language UK) programme, ‘Early Talk Boost’ is available in 11 playgroups and nurseries in Lisburn. It improves children’s attention and listening and their understanding of words and sentences. It also improves speaking and communication.

4. The ICAN programme, ‘Talk Boost’ is available in 14 primary schools in Lisburn. It can boost children’s ability in conversations, sentences, storytelling and social interaction by an average of 9 - 18 months.

Help Kids Talk is a partnership led jointly by the SEHSCT Speech and Language Therapy team and Early Intervention Lisburn. It is based on the successful ‘Stoke Speaks Out’ model of delivery which was set up in Stoke-on-Trent to help the high number of children with speech difficulties, by training parents, carers and families. After a seven year journey, the project was officially launched in March 2020. It is currently funded by Lisburn and Castlereagh City Council.

The steering group is comprised of representatives from community, voluntary, statutory and private sectors including: Public Health Agency, SEHSCT, Northern Ireland Childminding Association, Libraries Northern Ireland, Barnardo’s, Sure Start and staff from the local schools and nurseries.

There are connections with parents and carers through 37 partners (early years’ settings, playgroups, nurseries, and primary schools), social media, training, and a parent representative group.

Throughout the planning, implementation and development of Help Kids Talk, there has been a strong emphasis on co-design and co-production. The steering group and the parent representative group members have provided valuable insight and experience to inform the decision-making process. This co-production has strengthened the project and ensures we are achieving our overall vision of everyone working together to provide better outcomes for our children and young people.

The project collates data on:

- social media engagement and growth – this is collated on a monthly basis through Twitter, Instagram and Facebook analytics so we can measure what posts are relevant for our audience and measure the reach of the project through social media platforms
- number of people attending Basic Awareness training and the difference it has made – this is collated using a registration form, a training database and an online survey
- number of children and number of settings who have completed targeted programmes (Early Talk Boost and Talk Boost) and the difference it has made – this is collated through an ICAN and Help Kids Talk report at the end of every academic year

Measuring outcomes at population level for early intervention is difficult however there is a commitment from partners across all sectors to provide sustainable support to ensure our children and young people have the best chance in life.

Outcomes

Social media

Help Kids Talk has over 3000 followers across Twitter, Instagram and Facebook (**79% increase** since August 2020)

Social media feedback:

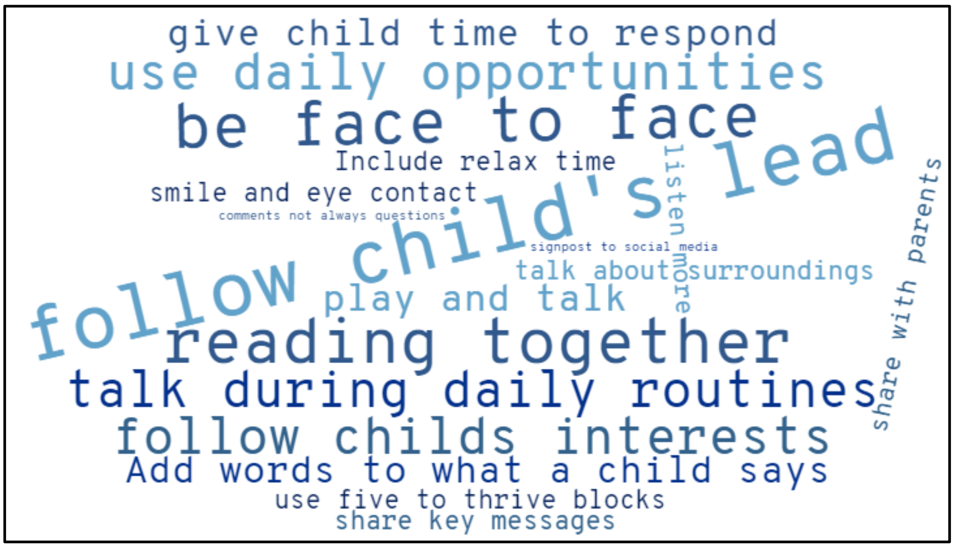
- *"I love reading all the insta posts as at 16mths my son was literally saying nothing so I felt myself reading all your posts about speech and development and was able to relate to a lot of them…he is now stringing sentences together*!"

Basic Awareness Training

725 individuals have attended Basic Awareness training since January 2020. Before training, **48%** participants rated themselves as mostly confident/confident supporting speech, language, and communication, this figure rose to **80%** after training.

Feedback following Basic Awareness training:

- *"I cannot thank you enough for creating that course last night. You were so engaging and everything I learned I have been implementing already at home and in playgroup"*
- *"I can now show these slides to hubby to show him I haven't completely lost it when I sing about her nappy as we change it"*
- *"This presentation highlights the importance of constant chat with wee ones and encourages everyone to develop talking skills"*



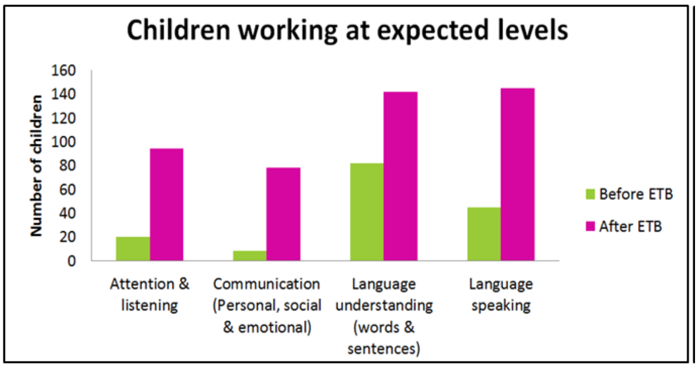
Word cloud showing strategies participants will use to support speech, language and communication skills following Basic Awareness.

Targeted programmes

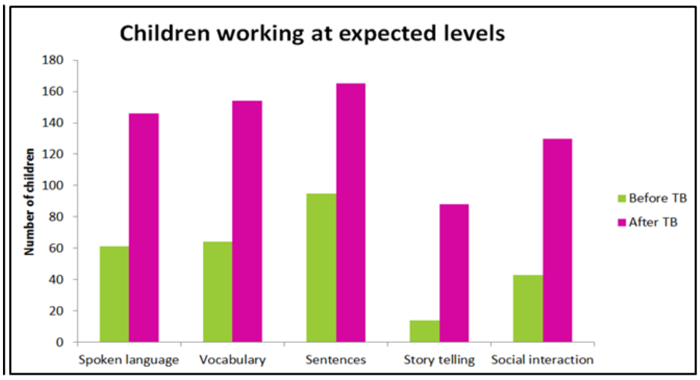
Just under **400 children** have received targeted support to support their speech, language, and communication. The graphs* below show the impact this has made for those children (*based on 203 children who have completed Early Talkboost and 179 children who have completed Talkboost from September 2016 to July 2021; this includes some pilot work pre-launch).

Help Kids Talk partners are supported to embed speech, language and communication support into their core work. In doing this, we create sustainable support for children's communication development. The link between infant mental health and speech, language and communication is a priority within the project. Creating better opportunities for bonding, attachment and communication leads to long term positive impacts for children's mental health and wellbeing.

Early Talk Boost



Talk Boost



Investment in the provision of training and resources to our partners ensures children receive intervention as early as possible and reduces potential future education or healthcare costs. For example, a child in one of our local nurseries was identified as a candidate for special educational needs (SEN) provision. His speech, language and communication skills were supported by nursery staff, he completed Early Talk Boost and was given a place in a mainstream primary school. In primary school, he continued to receive support for his speech, language and communication and completed Talkboost. As a result, the child has remained within mainstream education and has not required a place within SEN provision.

Key learning points

Help Kids Talk developed a bottom-up approach by bringing together partners from across community, voluntary, statutory and private sectors to collectively plan and make shared decisions to improve outcomes for children and young people.

This partnership-working has moved organisations from working in silos to working together and will provide long-lasting benefits to those living within our local communities.

Sustainability has been a driving force right from the beginning of the project and all training and support provided is looked at through the implementation within core provision.

Further aims have been identified, eg the development of a project like Help Kids Talk to help and support all children in need including ethnic minorities and children with a disability such as autism, learning difficulties.

References and useful links

Courtney, R. (2012) *The Best For Every Child Report*

Jordan, J.A. & Coulter, L. (2016) Individual Differences in

Speech and Language Ability Profiles in Areas of High Deprivation. *Child Care in Practice*. Available from: doi: 10.1080/13575279.2016.1188759

http://www.stokespeaks.org

https://fivetothrive.org.uk

https://ican.org.uk/training-licensing/i-can-programmes/early-talk-boost/

https://ican.org.uk/shop/talk-boost-ks1-intervention-pack/

http://www.facebook.com/helpkidstalk/

http://twitter.com/HelpKidsTalkNI

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Sport for Confidence and Stay Connected:
Creating an online physical activity service

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Description

Sport for Confidence CIC is a unique and innovative organisation, which brings together occupational therapists and specialist sports coaches to provide activity-based assessments and interventions for marginalised groups across Essex. Sport for Confidence typically operates within leisure centres, but during the coronavirus pandemic the Stay Connected service was created - an online service that utilises occupational therapists and sports coaches to provided support to marginalised populations, such as disabled people and people living with long-term conditions.

Context

The Stay Connected service enables participants to access and engage with a wide range of online interest groups, low and high intensity physical activity groups, and vocational groups. The occupational therapists enhance this offer by providing additional telephone contact, occupational assessment, active listening, empathy and personalised advice. The service also works in partnership with care and community providers to enhance resilience and accessibility of existing provision, supporting them to develop and embed sustainable and inclusive online solutions.

The Stay Connected service was originally commissioned in April 2020 for 6 months, to offer immediate support to disabled people living within Essex due to the pandemic. The service proved successful, and an extension was granted. Stay Connected is a person-centred service, which focuses on meeting the needs of individuals who face barriers in initiating, accessing and sustaining contact with support services. This is because these individuals are often the most at risk of experiencing a deterioration in their mental and/or physical health, exacerbated by the requirements to socially distance, shield and/or self-isolate. These individuals are also known to encounter inequalities in sport and physical activity participation, which has consequences for their health and well-being (English Federation of Disability Sport, 2013; Sport England, 2016). The service recognises the broader context of people's lives and how this relates to their health and well-being. Therefore, assessment and support is also offered to those in a caring role (whether paid or unpaid) to reduce the risk of carer breakdown. This further supports national policy that seeks to enable people with health conditions and impairments to live an active lifestyle (English Federation of Disability Sport, 2016).

Method

The service started with telephone and email contact and developed to providing regular Zoom exercise classes alongside occupational therapy assessment and support. The following demonstrates keys stages in the service improvement:

- Started with a basic service telephone and email contact service
- Awareness raising sessions (live social media events, providers and health and social care workers)
- Strengthen existing and new partnerships and referral pathways (e.g. Enhanced Social Care Support for Adults with LD/Autism team).
- Reviewed and changed measurement to qualitative data collection only to enhance rapport building and connection with the member of staff.
- Gradually increased and adapted the offer to include: personalised support ranging from, a short phone call to regular and lengthy contacts subject to needs assessment, signposting, email contact, personalised physical activity videos, zoom sessions, resources sent/ recommended.
- Posted infographics of monthly contact via social media
- Provided a weekly zoom timetable
- Co-created resources with Team Create (includes participants with lived experienced of disability/mental health/LD) to use within sessions (e.g. 'How to start a conversation about PA')

Outcomes

- The service was initially measured using self-rated measurement tool but feedback from the participants led to qualitative measurement, using feedback and case studies.
- Total referrals April 2020 – Feb 2021: 1157
- Current Caseload as of 1st March 2021: 129
- Total Zoom sessions delivered for January 2021: 41
- Total Zoom sessions delivered for February 2021: 41
- Total attendance at Zoom for January 2021: 576 interactions (average attendance of 14)
- Total attendance at Zoom for February 2021: 668 interactions (average attendance of 16)
- Average 0 – 10 rating given by participants on service provided: 9.7

There are many examples of what has changed, including:

- **Increased access to physical activity** (e.g. 5 days a week rather than 2x week in prior to covid)
- **Challenged assumptions** around people with a learning disability/Autism using digital platforms, we have enabled participants connect with new and old and stay connected with all.
- **Increased opportunity** for people to make independent choices about what activities they want to join. A choice of 14 different sessions a week was something that was not previously an option for the majority.
- Enabled participants to **safely try different sports and activities** they may not have tried before- enabling us to grade their exposure online and work towards them trying new things face to face in the future.
- Provided participants with **structure and routine**

Client feedback:

"This service has been helpful / useful by just knowing they are a phone call away in this difficult time of lock down uncertainty… keep up your amazing work! I am grateful to you all for your help and support and the belief you all have in me to achieve and grow as a person".

Family feedback:

"My son has Down's syndrome and attends a Sport for Confidence session; the therapists have kept these going each week via Zoom. This has allowed him to keep in touch with everyone, which given his additional needs he would not have been able to do… the variety of activities is great… the care and attention put in by the therapists is outstanding".

"Everyone at SfC has been amazing, all the team are so caring. My son is a completely different person since participating in the Stay Connected service."

Carer Feedback:

"The team have made me feel part of the 'outside world indoors" Thank you.

Provider feedback:

"We have been given lots of suggestions and physical activity information. Our client has now been offered a fantastic Video Carephone thanks to Stay Connected and they have been supporting one of our clients regularly".

The extension and how the service is evolving suggests the service is respected and valued by the commissioners who want it to remain. The consistent number of referrals suggest the service is of value to health professionals and participants.

Key learning points

- Learning to evolve with time and acting quickly, Covid has been a roller coaster ride and we have had to exhaust all our innovative creations to ensure that we can adapt to support the participants at their own pace.
- A single point of access has been a real important learning experience, something extremely valuable and as a consequence results in participants gaining efficient, sensitive and consistent support.
- Technology is difficult to navigate, however, it can be done with attention and care.
- The iterative approach we have taken has enabled us to adapt and change our approach as we go, therefore we have consistently followed check, challenge and change principles.
- It's clear there is a long term need for virtual and face to face delivery, to promote choice and independence for participants.
- To explore how this service becomes a long-term plan as part of Sport for Confidence and the participants we see.

References

English Federation of Disability Sport (2013) Microsoft Word - Active Together Report V6 (sportanddev.org) Accessed in April 2021

English Federation of Disability Sport (2016) English Federation of Disability Sport - Impact Report 2016-17 (activityalliance.org.uk) Accessed in April 2021

Sport England (2016) sport-england-towards-an-active-nation.pdf (sportengland-production-files.s3.eu-west-2.amazonaws.com) Accessed in April 2021

Improving the Quality of Orthotics Services in England

NHS England INFORMATION READER BOX

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Description	This document sets out a case for action to tackle the rising demand and variation in access and quality of services experienced by children and adults requiring orthotic care in England. It explains why it is important to improve the commissioning of services in terms of clinical and cost benefits and discusses some of the key issues affecting services currently, along with the experiences that patients and their families have had in using those services
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Superseded Docs (if applicable)	N/A
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Document Status

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Improving the Quality of Orthotic Services in England

Version number: Final

First published: November 2015

Prepared by: Neil Churchill, Director of Patient Experience, Cathy Regan, Associate Consultant, Primary Care Commissioning

Classification: (OFFICIAL)

Equality and Health Inequalities Statement:

Promoting equality and addressing health inequalities are at the heart of NHS England's values. Throughout the development of the policies and processes cited in this document, we have:

- Given due regard to the need to eliminate discrimination, harassment and victimisation, to advance equality of opportunity, and to foster good relations between people who share a relevant protected characteristic (as cited under the Equality Act 2010) and those who do not share it; and

- Given regard to the need to reduce inequalities between patients in access to, and outcomes from healthcare services and to ensure services are provided in an integrated way where this might reduce inequalities.

Contents

1 Foreword

Orthotics services play an essential role in enabling quality of life for people with long term conditions, disabilities and limb loss. Being able to access the right orthotics equipment, quickly, and with appropriate support, is of paramount importance. Unfortunately, this doesn't always happen. People can find themselves waiting a long time for equipment and develop secondary health complications. Long waiting times mean that children in particular may have grown before their orthotics equipment finally arrives. These are avoidable and unfair inequalities.

A number of published reports over the last decade and more have discussed the potential benefits of improving orthotic services, including significant health and quality of life benefits for patients, financial benefits for the NHS and economic benefits for the wider economy if a comprehensive, integrated orthotics service is provided consistently throughout the patient pathway. Despite this, challenges with effective commissioning and provision of orthotics services still remain and patient feedback indicates variation in service provision. Quality can suffer for a number of reasons but the lack of quality measures and data have hindered effective commissioning. The failure to get things right first time for the patient is resulting in avoidable inequalities in access, worse outcomes, poor patient experience as well as poor value for public money and unnecessary costs to the NHS, meaning less is available for services for people.

In recent months a number of Clinical Commissioning Groups (CCGs) and NHS Trusts have been working to put that right. Some are now able to provide highly personalised care and next-day delivery for standard orthotics products. We have identified a number of effective models which achieve excellent outcomes and levels of patient satisfaction, some provided in-house in acute trusts or in the community, others outsourced to the private sector. The benefits of this improvement work mean better access through reductions in waiting times for assessment and fitting of orthoses, higher activity levels at reduced costs, more focus on achieving outcomes and a better overall experience of care for patients.

This report has been published following a formal escalation regarding the poor quality of some orthotics services from Healthwatch England in 2014. It incorporates findings from a review[1] undertaken by the NHS Quality Observatory of available data about the quality of orthotics services and commissioners' ability to assure the quality of these services. This review was considered at a round table event in March 2015 for commissioners, service users, professional and trade associations and clinical leaders from across England, where we also listened to patient experiences and shared case studies from CCGs and providers who have worked to improve the quality of services. This document sets out the key issues discussed and the learning from that event and we hope will help raise the profile of the need for effective commissioning of orthotic services both nationally and locally and provide some practical tips on how to do it. This will be the start of further discussions and work about how we can improve outcomes so that people with complex and changing

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[1] A. Chavda., K. Cheema (2014) Analysing orthotics: availability of data and information in orthotics services in England, NHS Quality Observatory, Horley.

needs can always get the right equipment in a timely way, with appropriate and continuing support.

Neil Churchill, Director for Patient Experience

Suzanne Rastrick, Chief Allied Health Professions Officer

2 Executive summary

This document sets out a case for action to tackle the rising demand and avoidable inequalities in access and quality of services experienced by children and adults requiring orthotic care in England. It explains why it is important to improve the commissioning of services in terms of patient care, clinical and cost benefits and discusses some of the key issues affecting services currently, along with the experiences that diverse patients and their families have had in using those services. Some case studies are presented from CCGs and providers who have worked to improve the quality of services and commissioning tips are provided for CCGs wishing to improve and redesign local services for the future.

Aligned with NHS England's Five Year Forward View, it supports a preventative approach through effective commissioning and provision of quality orthotic care to meet the growing challenge of an ageing population and increasing health needs associated with major clinical conditions including obesity, cardiovascular and peripheral vascular disease, diabetes and stroke. It also stresses the need to develop quality metrics to monitor orthotics services and encourages a move towards more outcome based commissioning and improving equity for patients.

The shared learning from the round table event and case studies highlight a number of common elements that commissioners and providers should consider in redesigning and improving orthotics services to secure efficiencies and quality improvements for patients, namely:

- Continuously engage and involve patients and their families;
- Include patient focused and outcome measures / KPIs in service specifications;
- Implement direct access referral for general practitioners, allied health professionals, registered nurses and consider self-re-referral for appropriate patients;
- Define criteria to accommodate the needs of children and patients requiring urgent treatment;
- Encourage adoption of multidisciplinary approaches and ways of working to maximise skills and efficiency;
- Consider introducing local tariffs for orthotics services.

These form the basis of a number of recommendations aimed at CCGs to help improve effective commissioning of orthotics services which are summarised in section 6.

A number of actions to help improve orthotics services in England were agreed as a result of the round table event and are outlined in section 8. Some of these have already been implemented, for example, the development of a model service specification (https://www.england.nhs.uk/wp-content/uploads/2015/11/orthcs-serv-spec.docx).

It is now imperative that the NHS finds the correct approaches to bring about national and local change that will support the drive to improved patient outcomes for those needing orthotics services alongside efficiency. NHS England is committed to working with CCGs and other key stakeholders to ensure these actions are implemented so that this review will have the impact that others have not for the direct benefit of those who use these services.

3 Introduction

3.1 Orthotics is a speciality involving application of external devices to the body to support and improve posture, function and mobility and manage pain and deformity. “Orthoses” is the term used to describe the external devices and includes insoles, braces, splints, callipers, footwear, spinal jackets and helmets. Compression hosiery can sometimes be provided as part of the orthotics service. Orthotists are generally the designated professionals responsible for the assessment, prescription, design, manufacture and fitting of orthoses to patients. The role of the orthotist is to consider and discuss with the patient the type of orthoses that will best meet his or her needs. Increasingly, this role is undertaken by other allied health professionals involved in a patient’s care such as podiatrists, physiotherapists and others.

3.2 Orthotics services provide treatment options for people with a wide range of conditions and orthotists work closely with a number of clinical specialties within the NHS including diabetes care, elderly medicine, neurology, orthopaedics, paediatrics, stroke and trauma teams. The correct supply and fitting of orthoses can help improve quality of life by reducing pain, keeping people mobile and independent and preventing more invasive and expensive interventions like surgery, amputation or the need for social care. As a result, the provision of orthotics plays a major role in many rehabilitation programmes. The NHS England Rehabilitation Programme defines rehabilitation as “the development, to the maximum degree possible, of an individual’s function and/or role, both mentally and physically, within their family and social networks and within education/training and the workplace where appropriate”. Good rehabilitation services deliver early intervention, restore or retain independence as much as is possible and enable people to live their lives. Orthotics services play a vital role in the rehabilitation pathway for many people and as such must offer effective, quality and timely interventions to ensure people reach their maximum potential.

3.3 Orthotics service provision in the NHS has been the subject of a number of reviews and reports spanning the last twenty years and more. The Disabled Living Foundation detailed longstanding problems in the provision of therapeutic footwear in its 1991 report[2]. In 1992, the Department of Health commissioned a critical review of the organisation of orthotics services in England and Wales.[3] The Audit Commission produced reports in 2000[4] and 2002[5] which highlighted serious problems with the quality of orthotics services and provided commissioning guidance for Primary Care Trusts in 2004[6] recommending increased levels of service provision, better access to services, and collaboration among multidisciplinary teams. The *“Orthotic Pathfinder”* report[7] identified several problems with the structure of orthotics services and the

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[2] Disabled Living Foundation. "Footwear: a quality issue: provision of prescribed footwear within the National Health Service." ;1991

[3] Bowker P, Rocca E, Arnell P, Powell E: A study of the organisation of orthotic services in England and Wales. Report to the Department of Health, UK; 1992.

[4] Fully Equipped – The provision of disability equipment services to older or disabled people by the NHS and social services in England and Wales. 2000, Audit Commission

[5] Assisting Independence - Fully Equipped 2002. Audit Commission.

[6] Guidance on the Commissioning of Orthotic Services, 2004, Audit Commission

[7] Orthotic Pathfinder – “A patient focussed strategy and proven implementation plan to improve and expand access to orthotic care services and transform the quality of care delivered” NHS Purchasing and Supply Agency; 2004.

significant benefits to be gained by the NHS, both in terms of improved quality and cost savings if these problems were resolved. In particular, it recommended condition specific direct GP Access to orthotics services and highlighted that for every £1 spent on improving orthotics services, the NHS could possibly save as much as £4. The potential impact of early orthotic intervention and improvements in service provision on health and quality of life benefits for patients, financial benefits for the NHS and economic benefits for the wider community were re-iterated in the York Health Economics Consortium report in 2009[8] and the Centre for Economics and Business Research report in 2011[9].

3.4 Most of these reviews and reports draw similar conclusions and support improved commissioning and provision of better resourced and more integrated orthotics services. They also highlight how orthotics services can help achieve some of the major policy objectives of the NHS. These include: reducing referral to treatment times; hospital admissions; the need for acute treatment; facilitating choice for people with long term conditions with better management and rehabilitation; and keeping people mobile and independent and therefore reducing the need for social care services, as well as getting people back into work or education. All of these contribute to reducing health inequalities. The York Health Economics Report[8] summed up the potential in the following statement:

"*Orthotic provision has the potential to achieve significant health, quality of life and economic benefits for the NHS if a comprehensive, integrated service can be provided, throughout the patient pathway. Service planning and contracting arrangements which emphasise the delivery of an integrated and comprehensive orthotic service are more likely to achieve the benefits to the NHS identified in the many reports."(p.10).*

3.5 Despite the consensus on the potential benefits of improving orthotics services, most agree it is still a "Cinderella service", poorly understood and generally not viewed as a priority for development[7] [8] [9] [10] [11]. In addition, the service is often "hidden" as part of other pathways of care contributing to the poor understanding, silo working and increasing confusion about access for patients. Concerns about the poor quality of services remain with patients, their families, clinicians and other stakeholder organisations raising issues about access, quality and variability of orthotics services more recently.

3.6 In July 2014, NHS England responded to a formal escalation by Healthwatch England about the quality of services nationally by commissioning a review, undertaken by the NHS Quality Observatory, of the data available on the quality of orthotics services and commissioners' ability to assure the quality of these services. The findings of the review[1] were shared at a round table event in March 2015 for commissioners, service users, professional and trade associations and clinical leaders from across England. The event also provided the opportunity to listen to the patient experience of those using orthotics services as well as share examples of

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[8] Hutton, J., and M. Hurry. "Orthotic Service in the NHS: Improving Service Provision" York Health Economics Consortium, Univ. of York;" 2009.

[9] Centre for Economics and Business Research Ltd . The economic impact of improved orthotic services provision - A review of some of the financial and economic benefits of a better functioning system for the provision of orthotic services; 2011.

[10] Scottish Orthotics Services Review, 2005, NHS Scotland

[11] British Association of Prosthetists and Orthotists, 2015: Improving the Quality of Orthotic Services in England.

effective commissioning and service delivery models, with the aim of sharing good practice and facilitating further action nationally and locally to improve commissioning and provision of orthotics services.

3.7 As mentioned previously, orthotics plays a major role in rehabilitation programmes for children and adults with a range of conditions and in many respects, the issues and challenges affecting orthotics services mirror those highlighted in recent NHS England initiatives targeted at improving rehabilitation and wheelchair services. The *Improving Rehabilitation Services Programme* aims to deliver rehabilitation at the right time, in the right place by the right person for all children, young people and adults in England so they are able to live long, happy and productive lives. NHS England is also working with a number of partner organisations to improve wheelchair services. Both areas have uncovered issues with access, quality and variation in service provision which NHS England is tackling in a number of ways. Improvement priorities for rehabilitation services include: exploring levers and incentives; establishing the economic benefits of rehabilitation and developing an economic model for service provision; and establishing the case of need for improvement in children and young people's rehabilitation services. Priorities for improving wheelchair services are: the development of a national data set; piloting of a tariff for wheelchair services; and the development of resources to support commissioners of wheelchair services.

3.8 The aim is for NHS England to prioritise the improvement of access for people and their experience and outcomes of orthotics services. The purpose of this document is to raise the profile of the need for effective commissioning of orthotic services both nationally and locally and re-invigorate the historic debate for change.

4 The Case for Action

4.1 *"Early orthotic intervention improves lives and saves money"* [8]*(p.1)* and yet the benefits to the NHS are still not fully realised by most commissioners and managers[9]. In this section, the clinical and cost benefits of orthotics services are discussed and the key challenges that need to be addressed are outlined, based on information and evidence from previous papers and reports and re-iterated further in discussions at the round table event.

Clinical Benefits

4.2 The provision of orthotics has a beneficial impact on a range of clinical conditions by relieving pain, increasing mobility, protecting tissues and promoting healing along with a whole host of other benefits including improved independence and self-image.[10] [12] The range of clinical conditions benefiting from orthotics includes chronic diseases and trauma as well as neurological, musculoskeletal and congenital conditions. A number of these remain as policy priorities for the Government and the NHS, examples of which are set out below:

- Diabetes – prevention and reduction of ulceration rates and amputation;

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[12] All-Party Associate Parliamentary Limb Loss Group, 2014: Patient Led Orthotic Services Patients Charter

- Stroke and other neurological conditions such as multiple sclerosis and cerebral ;palsy;
- Chronic Obesity – often leading to Type 2 diabetes and musculoskeletal problems;
- Cancer – managing the side effects of chemotherapy (peripheral neuropathy);
- Cardiovascular, including peripheral disease – effects of poor circulation;
- Degenerative conditions – rheumatoid arthritis and osteoarthritis;
- Congenital conditions - spina bifida;
- Spinal cord injury and scoliosis;
- Complications of viral infections such as polio;
- Common musculo-skeletal conditions and sports injuries - maintaining mobility and returning people to work sooner
- Treatment of the frail and elderly such as falls prevention.

4.3 Commissioners and managers should be aware of the positive impact that orthotics services can have on commissioning priorities such as the reduction of hospital admissions, accident and emergency (A&E) attendances and prevention of complications from diabetes, peripheral vascular disease and cancer. Appropriate orthotic management of patients with these conditions can delay and reduce the need for more expensive and complex treatment and the need for surgery. In addition, there are also benefits to wider health and social care priorities including promoting well-being and supporting independence in the community, for example by reducing the probability of falls in frail, older patients and keeping them mobile and independent reducing the need for social care. All of which contribute to reducing inequity.

Benefits for Children and Young People

4.4 It is particularly important that children and young people needing orthotic intervention get it quickly and that the orthoses are well fitted and of good quality. If they have to wait many months to obtain the correct orthoses, most will have outgrown them before they are fitted and endured unnecessary pain and immobility. This is unfair. It also undermines the work of the rehabilitation team and sometimes results in the need for further surgery and dependency on a wheelchair. This affects not only their physical health but also their psychological, emotional and social health. Children and young people will have changing needs as they develop and require responsive and flexible orthotics service provision. If not addressed these young people face avoidable inequalities.

Cost Benefits

4.5 The cost benefits to be gained by improving the commissioning and provision of orthotics services are well argued in previous reports[7] [8] [9]. In summary, savings are likely to be made by treating more people in primary care and reducing the need for consultant appointments and more expensive acute care procedures, in-patient stays, drugs and surgery. Most savings are expected to be made by keeping frail, older people mobile and independent for longer and reducing the need for expensive social and residential care services[9]. In quantitative terms, the *“Orthotic Pathfinder”* report estimated that the economic and social consequences of denying patients orthotic care are significant, costing an estimated £390 million per annum based on

2004 data. It suggested that for every £1 spent on improving orthotics service provision, the NHS could save £4[7].

4.6 The York Health Economics Consortium report quantified the potential cost savings of using orthotic interventions in primary, acute and long term conditions case studies compared to traditional secondary care treatment and surgery. Significant cost savings were demonstrated in the treatment of plantar fasciitis, ruptured achilles tendon and management of diabetic foot complications respectively[8]. Similarly, the Centre for Economics and Business Research report worked out potential financial savings to the NHS and social care through the better use of orthotic interventions in the treatment of plantar fasciitis, diabetic foot complications and stroke. In addition to the specific cost savings estimated for each condition, it was estimated that around £48 million could be saved by re-locating orthotics services from secondary to primary care[9].

4.7 In practice there are examples of delays in early orthotic intervention resulting in increased costs of care to the NHS as experienced by Rebecca and Des and their son David. David had a stroke in the womb so has a condition called hemiplegia which is a one sided form of cerebral palsy and has required orthotic care from when he first began to stand. In the early part of David’s childhood, it was a struggle to get the speedy and responsive orthotic care he needed to keep up with his growth. It would usually take 18 weeks from identifying need to obtaining the support for his foot and ankle. At least four pairs of expensive orthopaedic boots had to go into clinical waste either at the point of provision or within a few weeks because they were too small.

4.8 By the age of nine, David’s ankle and foot were getting more and more deformed. The family believe this was a direct consequence of his poor access to orthotic care. His orthopaedic surgeon recommended serial casting to set his foot straight with the associated increased costs to the NHS of:

- 5+ outpatient appointments with the orthopaedic surgeon and nursing team lasting over an hour each to cut off each plaster cast, wash his foot and reapply a new plaster cast;
- An attendance at A&E when one of the casts was applied too tightly.

4.9 David should have had an ankle foot orthosis (AFO) to wear immediately after serial casting to keep his foot and ankle straight. It took 17 weeks to get one and within days he had lost all his mobility and even the ability to weight-bear. The further costs of this to the NHS included:

- a wheelchair assessment;
- a wheelchair;
- months of intensive physiotherapy to try and recover the damage;
- a 10 week course of counselling for David due to the psychological and emotional stress caused by this situation;
- a six week parenting course the parents had to attend in order for him to be considered for counselling;
- complex foot surgery at a Children’s Specialist Hospital out of area;
- outpatient follow ups at the Children’s Hospital;

- more frequent reviews by his local paediatrician due to the impact on David's progress and development;
- occupational therapy advice to address his mobility in the home.

4.10 In addition to this increased financial cost to the NHS of delayed, poor care, the personal cost to David in terms of his development, education and emotional well-being were catastrophic. The impact on the whole family was immense both emotionally and financially. A real example of what is meant by avoidable and unfair health inequalities.

4.11 Clearly the potential cost savings associated with improved orthotics service provision warrants further consideration by CCGs and policy makers alike.

A Growing Challenge

4.12 It is a challenge to obtain accurate figures on the numbers of people in England treated by orthotics services currently, partly due to the complexity of pathways of care and as availability and accessibility of data in this area is poor, which was highlighted recently in the national review of orthotics data commissioned by NHS England[1]. The last known, referenced figure of 1.2 million[7] [8] was based on the 2007 report produced by The Foundation for Assistive Technology[13] which suggested using this number as a guide only as the total number of people benefiting from orthotics was unknown. An extrapolated figure based on a compound annual growth rate of up to 6% over 2010-2017, stated by *Global Pipeline Analysis, Competitive Landscape and Market Forecasts for Orthotics and Prosthetics*[14] would put current estimates at around 2 million.

4.13 This number will continue to grow, firstly due to expected increases in the ageing population. The majority of people requiring orthotic services are over 50 years of age[7] and the Office for National Statistics (ONS) forecasts that the English population aged 55 and over will have increased by 35 per cent from approximately 14.8 million in 2011 to 20 million in 2031[15]. At least 23 per cent of the total projected population of 60.4 million will be 65 and over[8]. This is likely to lead to an increase in demand for orthotics services.

4.14 The other factors affecting growth in demand are the rising prevalence of obesity, cardiovascular and peripheral vascular disease, diabetes and stroke[8] [15] [16]. Predicted rates of obesity are likely to affect around half the population by 2050 according to the UK Health Forum[17]. Obesity can contribute to musculoskeletal problems and is a major risk factor for developing diabetes and cardiovascular disease; in fact diabetes doubles the risk of developing cardiovascular disease[18].

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[13] Down K, Assistive Technology Workforce Development. The Foundation for Assistive Technology. June 2007.

[14] http://www.businesswire.com/news/home/20110419006508/en/Research-Markets-Orthotics-Prosthetics---Global-Pipeline#.VWcvw9JViko

[15] Centre for Workforce Intelligence, 2012: Workforce Risks and Opportunities. Prosthetists and Orthotists. Education Commissioning Risks Summary from 2012.

[16] National Allied Health Patients' Forum. 2011: Patient Concerns over the shortage of Prosthetists & Orthotists

[17] UK Health Forum, 2014: Obesity rates are rising but new predictions by National Obesity Forum may be an overestimate according to UK Health Forum. http://nhfshare.heartforum.org.uk/RMAssets/NHFMediaReleases/2014/Statement%20from%20UK%20Health%20Forum%20on%20NOF%20report.pdf

[18] NHS England, 2014: Action for Diabetes

Estimates suggest that the number of people with diabetes is likely to increase by 5% year on year from over 2.5 million people currently to more than 4 million by 2030[15]. Diabetes and cardiovascular /peripheral disease often result in foot complications, the worse-case scenario being amputation. Approximately 100 people a week have a lower limb amputated as a result of diabetes which could be avoided with the help of preventative foot care including appropriate orthotic provision[19].

4.15 Improvements in neonatal care mean that children are surviving with more complex disabilities and this together with the expansion of the ageing population and prevalence of major clinical conditions will impact significantly on the NHS and social care budget. They can all benefit from cost effective orthotic intervention.

4.16 The Five Year Forward View**Error! Bookmark not defined.** supports a preventative approach to the growing challenge of increasing health needs and encourages improvement in both the commissioning and integration of services and providing innovative models of care, ensuring that people of all ages are actively supported and empowered to lead the lives they want for themselves and their families in the best possible health. This would lead to reduced inequalities in access to services and the outcomes achieved. It will be important for CCGs to consider the Five Year Forward View and the factors affecting increased need for orthotics services in their commissioning decisions and to take account of this predicted growth in demand in the future commissioning and redesign of orthotics services.

The Data Challenge

4.17 The national review of orthotics data commissioned by NHS England and undertaken by the NHS Quality Observatory in 2014 concluded there was minimal routine, quantitative data accessible and available to review the quality of orthotics services and understand how they were delivered around the country[1]. The reasons behind this are predominantly due to coding issues, poor recording, block contracts with lack of tariff incentives, multi-speciality referrals “hiding” orthotics related information and commercial sensitivity around data held by private companies.

4.18 This significant lack of data poses a challenge for CCGs. The review expressed the need for a clear mandate to identify and collect process, outcome and patient experience measures from orthotics services that could be regularly monitored and reviewed to assess quality and identify areas of best practice. In particular, it recommended that a national data collection tool be developed in collaboration with commissioners of orthotics services and the British Association of Prosthetics and Orthotists (BAPO) to help inform an ongoing dataset to improve the information available on the quality of orthotics services.

4.19 The review also considered data obtained by Medway NHS Foundation Trust in response to its national orthotic service questionnaire which highlighted significant variation in a number of elements of orthotics service provision across the UK. These are discussed in more detail in the next section. Whilst this was not a formal audit commissioned by NHS England, the NHS Quality Observatory review acknowledged it had produced useful data to illustrate the lack of parity and equity of orthotics

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[19] Diabetes UK, 2013: Putting Feet First https://www.diabetes.org.uk/Documents/campaigning/Putting-feet-first-campaign.0213.pdf

service provision. It suggested a more formal audit process should be developed and implemented and this should be considered further by commissioners and policy makers.

The Quality Challenge

4.20 In addition to the lack of data available, there is also a lack of clear and measureable standards for orthotics services which results in the variation of access and quality around the country mentioned in various reports[1 7 12] and is the cause for concern for patients, their carers and organisations such as The Orthotics Campaign[20], the All-Party Associate Parliamentary Group on Limb Loss[12], Arthritis Research UK[21] and Healthwatch.

4.21 This may be due to the fact that historically orthotics services have been commissioned using a "commodity product" model based on volume and price rather than quality and outcomes[8 12]. It is also a result of the lack of specific policy guidelines for commissioners on what a "good" orthotics service looks like. Orthotics have been mentioned in National Institute for Health and Care Excellence (NICE) guidelines such as stroke rehabilitation, Type 2 diabetes foot problems and spasticity in children and young people with non-progressive brain disorders. These highlight the role of orthotics within a multidisciplinary team approach rather than provide specific measureable standards for orthotics services which commissioners can use to monitor and review quality.

4.22 The extent of variation in orthotics service provision was evident from the responses to a recent national orthotic service questionnaire conducted by Medway NHS Foundation Trust which was used to inform the data review commissioned by NHS England[1]. This looked at a number of areas including: staffing; clinical; waiting lists; budget and management; information technology; suppliers and procurement; geographical demographics; referral types; audits; patient experience and key performance indicators (KPIs). 55 organisations responded out of 188 surveyed in England, Wales and Scotland. The findings are indicative of significant variation and lack of consistency of provision of orthotics services supporting the continued notion of postcode lotteries[12]. For example, referral to treatment waiting times varied from 1 week to 58 weeks for both adults and children as illustrated in Figures 1 and 2 below.

4.23 The information analysed from the Medway questionnaire also found that not all services used KPIs and there is a lack of consistent KPIs monitored by those who do.

4.24 No doubt some of this variation is due to differences in the diversity of population demographics and case mix depending on whether a standard or more complex, specialised service is provided, as well as whether the service caters for children and adults only or both. However, what is clear is that variation and inequity do exist and the reasons why should be further explored.

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[20] http://www.orthoticscampaign.org.uk/what-pts-say.html

[21] Arthritis Research UK, 2012: A Call to Action: Providing better footwear and foot orthoses for people with rheumatoid arthritis.

Figure 1: Adult Waiting Times 2013/14

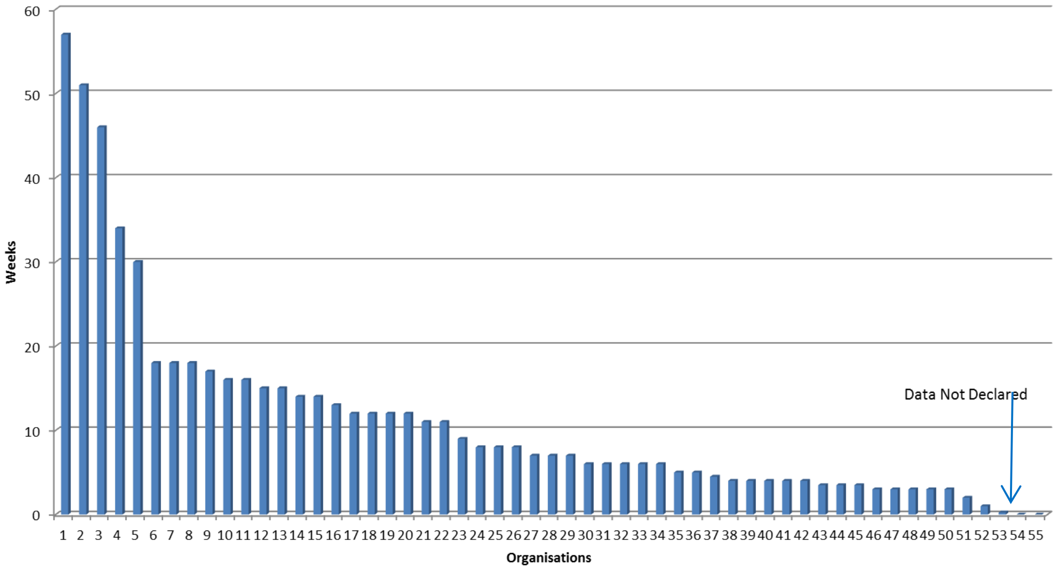
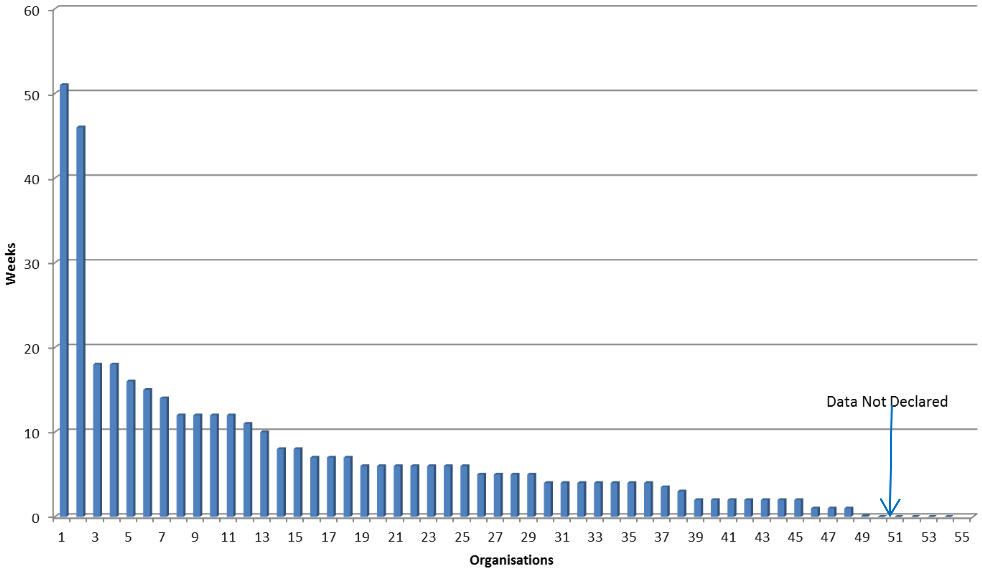


Figure 2: Paediatric Waiting Times 2013/14



The Workforce Challenge

4.25 The lack of data on orthotics service provision also relates to national workforce data, which is poor and incomplete. The number of orthotists working within the NHS is not accurately measured and reported[15]. Over 70% of orthotists are employed through sub-contracted companies in the private sector who deliver services on behalf of the NHS and do not have a unique occupation code for use in electronic staff records systems. However, the number of orthotists (and prosthetists) registered with the Health and Care Professions Council (HCPC) at the time of writing was 1012. Currently, fewer than 500 of these are estimated to be practicing as orthotists[11 22]

4.26 As discussed previously, the demand for orthotists is likely to rise in line with increases in the ageing population and rising prevalence of obesity, diabetes and cardiovascular and peripheral vascular diseases. However, there are major concerns regarding the current severe shortage of orthotists within the NHS[16 22] resulting from high attrition rates and a retiring workforce. The British Healthcare Trades Association (BHTA) view is that there will need to be a 30 to 50% increase in the number of orthotists to meet current and future demands of new models of care[22].

4.27 The lack of accurate workforce planning data needs to be addressed to identify current establishment and help plan for future supply. Recent initiatives providing guidance on career frameworks[23], education[24]and preceptorship[25] for prosthetics and orthotics should help to develop and sustain a flexible workforce and support commissioners in planning education and service development. They will also help support and promote skill mix and multi-professional working in integrated teams which is the approach needed to meet the increasing needs of patients and help tackle some of the current issues facing the orthotics profession, particularly within the context of scarce resources. In addition work is ongoing with the relevant professional and trade associations and educational establishments in Scotland to develop a national training programme for technicians involved in orthotic manufacture. This will be the first qualification of its type in the UK and will be launched in March 2016.

4.28 Some of the case studies presented in this document have adopted innovative approaches to reducing waiting times and improving orthotics services by developing a more multidisciplinary approach to the provision of orthotic care. This involves working with appropriately trained allied health professionals including podiatrists and physiotherapists, and registered nurses, as well as multidisciplinary clinics for specific conditions such as diabetes and others. This has had a positive impact and helped reduce waiting times for initial assessment as well as speed up in-patient treatment and reduce length of stay, therefore, a multidisciplinary team approach to the provision of orthotic care should be encouraged and considered in the redesign of orthotic services.

5 The Patient Experience

5.1 A key purpose of this document is to facilitate action in response to more recent concerns regarding the quality of orthotics services raised by patients and their families. They cover a range of issues such as unacceptable waiting times, lack of getting the orthotics fitted “right first time”, unrealistic clinic slot times, inconsistent product entitlements and generally poor quality services which have an impact on people’s daily lives affecting their level of pain, mobility and capacity to remain employed or attend school or higher education. The experiences of the few patients and their families presented here have been provided with kind permission by The

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[22] All Party Associate Parliamentary Group on Limb Loss, 2014: Campaign for More Orthotists.

[23] Health Education North West and University of Salford, 2014: Career Framework Guide Prosthetics and Orthotics

[24] Health Education North West and University of Salford, 2014: Education Framework Guide Prosthetics and Orthotics

[25] Health Education North West and University of Salford, 2014: Preceptorship Guide Prosthetics and Orthotics

Orthotics Campaign and help to understand the important issues from the patient perspective. They are a few examples of many, with well over a 130 patient/carer stories of poor quality NHS Orthotic care in England shared with The Orthotics Campaign to date. All show the reality of unavoidable health inequalities as result of poor services.

David's Story

5.2 As discussed previously, David, who is now 15 years old has received orthotic care since he was 18 months having been diagnosed with hemiplegia. The main focus of care in his early years was provided by a combination of orthopaedics, physiotherapy and orthotics to get him walking properly and prevent a foot deformity from developing. However, he and his family experienced long delays in getting appointments for the assessment and fitting of the orthotics he needed which sometimes led to waits of between 4 to 6 months. These delays were caused by a number of issues including staff shortages, poor administrative processes and outdated recording procedures. They generally resulted in the orthotics being the wrong size for David as naturally he would outgrow them during the long delays. The delays in care also meant that David only had sporadic access to a splint or pair of boots that he could actually tolerate or fitted properly without being in pain. This meant he did not get the full benefit of each orthotic intervention and then required further, more expensive intervention. In summary David went from needing Piedro boots to an ankle foot orthosis (AFO) and serial casting, only to wait 17 weeks for a properly fitted AFO. During this time he had to use a wheelchair and could not attend school as his classroom was upstairs. The personal cost to David of this poor care was a lot of pain, 17 weeks of lost education, lost mobility and the need for an unnecessary wheelchair. He also missed important family events and had difficulties managing and enjoying other family occasions such as holidays and a family wedding. He began to show his feelings and frustration about this and ended up needing counselling. Crucially he lost precious childhood experiences that he will never get back. As already mentioned, the wider impact of this on David's family was immense.

Simon's Story

5.3 Simon is a young adult with spina bifida. He usually has to wait for months or even years for new shoes to be authorised for him. He is only allowed 1 pair at a time. His shoes look really worn out and he feels embarrassed when he sees people looking at them.

Karen's Story

5.4 Karen has a young daughter who needs an AFO on her right ankle /leg and an orthotic insole for her left shoe to help her walk as her feet turn inward. She went for the casting of the heel cup for the left foot which took weeks to arrive and was too small. She was re-measured for a new one which was very hard and not well padded and caused blisters. The heel cup was returned for additional padding for extra comfort and as it had started to deteriorate. This incurred additional costs and delayed treatment for another 4 to 6 weeks .Karen's daughter also needed a hand support/splint for her right hand. It has been over a year since Karen requested this and she is still waiting. In the meantime, a lycra hand glove was made for her daughter which, on collection was too small. Again her hand and arm had not been measured properly and the glove had to be thrown away. Karen wonders why the orthotics cannot be made correctly the first time which would save money, unnecessary appointments and prevent the discomfort and long delays her daughter experiences.

Safeera's Story

5.5 Safeera is 16 and living with a degenerative muscular condition which leaves her with chronically weak muscles. From early childhood, she has needed a number of orthoses to help delay the onset of deformities, support her in a standing frame and maintain her everyday functioning. These have included the need for well-fitting foot splints (day and night); specialist footwear; a spinal brace (up to the age of 8); night-time wrist splints and a neck collar. Her mother describes the service provided in the early years as *"woeful"* having to experience ill-fitting splints that *"chewed"* Safeera's feet; spinal jackets that *"disappeared"* into her armpits leaving deep red tracks and hearing Safeera cry in her sleep due to the pain and discomfort caused. As well as this, Safeera often had to go to school in trainers, whilst the specialist footwear she needed sat on the shelf in the orthotics department because there was not an appointment to pick them up in time for the new term. The lack of responsiveness and flexibility of appointments often meant that Safeera's therapy and much needed orthotic intervention were delayed and hindered her progress. On top of this, there was one occasion when, after months of waiting for new splints they arrived and they were both for the left foot and the same vicious circle of waiting started again!

Diane's Story

5.6 Diane is 51 years old and has left sided hemiplegia. After a bout of suffering badly from pains in her legs and feet she conceded to needing help with footwear. She was referred to have a pair of shoes made. She felt embarrassed and ashamed that she needed help but still went along and had her feet measured and had imprints of her feet taken. She was shown the catalogue of shoes to choose from and was horrified. They were all unflattering and old fashioned. She waited months for the shoes to be made and although she did not like them, she was hoping for a comfortable pair of shoes to wear on a day to day basis. When the shoes arrived, they were far too big and slipped off with every step. After waiting weeks for an appointment to take them back, she saw a different orthotist who asked if she was sure she had been measured for the shoes. She is still putting up with her pain and now waiting for another fitting for her shoes. The whole experience has left her feeling angry and upset and she wishes she had not bothered. She believes that nothing can make her feel better about her disability and that she will never have a properly fitting pair of shoes. In Diane's view, the service offered for making footwear in the NHS needs a major overhaul.

5.7 These stories highlight examples of poor care; however some patients have a much more positive experience to share:

Keith’s Story

5.8 Keith has cerebral palsy and needs specialist orthotic shoes to help him walk. Without them he wouldn’t be able to go anywhere and would have no quality of life. He needs to visit his local orthotic service located in a large acute hospital trust every six weeks which is quite a long distance away from his home and costs at least £30 in travel costs each month. Keith is happy with the service he receives although couldn’t help thinking it would be far more convenient having a service closer to home. He discussed this idea with the head of the service and in less than two months non-acute orthotic treatments were offered in two additional community settings in more convenient local areas for patients, enabling those patients to be treated and followed up closer to home and saving them time and money. Keith was delighted that someone actually listened to his idea and made it happen. In Keith’s eyes this change will have a major positive impact on his life.

Factors affecting the Patient Experience

5.9 There are a number of factors affecting the patient experience of orthotics care in the NHS, some of which have been discussed previously. The Orthotics Campaign has categorised the main issues into nine key themes which are summarised below: (https://www.england.nhs.uk/wp-content/uploads/2015/11/orthcs-rep-attach-1.pdf).

- Commissioning (lack of guidance and data, historical bundling into procedural based and outpatient based tariffs, unintended consequences of block contracts and perverse incentives – income generation of surgery via payment by results versus cost of orthotic preventative care);
- Fragmented procurement (“commodity” approach rather clinical service with individual prescription tailored to needs; bureaucratic administrative processes adding to delays; focus on contract price, not timeliness and quality)
- Lack of quality standards and agreed KPIs;
- Service delivery (different provider models – lack of benchmarking, equity and consistency for patients)
- Substantial shortage of clinicians (impacts on waiting times and quality of service)
- Unrealistic clinical slot times not tailored according to the needs of the patient (clinics overbooked, waiting time delays and repeat appointments needed);
- Location of services - patients generally prefer a non-hospital setting with free parking close to the service;
- Access to bespoke footwear services when required according to need;
- Variation in patient entitlements;
- Education and specialist training (only one training centre in England, more courses required to facilitate multi-professional care)
- Stifled innovation (private companies have innovation ideas which may be too expensive for the NHS to implement)
- Skewed market forces.

What would a Quality Orthotic Service look like?

5.10 Much of the focus at the round table event was on what a good quality orthotics service would look like. Stakeholders at the event discussed key issues such as developing quality metrics to monitor orthotics services, what elements were important to consider in moving towards outcome based commissioning and the development of local tariff schemes for orthotics services, along with how the workforce would need to develop to support more outcome based commissioning.

5.11 From the patient perspective it was felt that the following key principles should underpin all services:

- Patients should have a voice in the decision making process throughout referral and service provision;
- The patient's quality of life should be better;
- Orthotics should cause no harm;
- It should not be a struggle to obtain them;
- The service should be timely and responsive;
- Care should be agreed and coordinated;
- Patients should expect consistency of care, for example seeing the same clinicians;
- The time and effort taken by the patient should be outweighed by the benefits to them;
- Quality is not measurable within one contact.

5.12 All stakeholders at the event expressed the need for national guidance to support more efficient commissioning and to be assured that orthotics services are of high quality and that outcomes are defined and reported. There were calls for the development of a model service specification for orthotics services which would cover agreed key elements and KPIs thought to be illustrative of a good quality service. Some of the key elements suggested and discussed included:

- Easy access via simple referral processes;
- Patient self-referral for follow up episodes once under care;
- Defined criteria to accommodate the needs of patients requiring urgent treatment and children who need a more responsive service and faster turnaround times to allow for growth;
- Agreed, acceptable maximum waiting times for first and follow up appointments;
- Agreed timescales from first appointment to supply of orthosis necessitating agreed timescales for manufacture by companies;
- Appropriately timed clinic slots for simple and complex cases;
- Named "orthotists" as case manager for a patient's care;
- Provision of patient information about their orthoses and care;
- Clear guidelines on patient entitlements;
- Agreed set of core KPIs to include patient outcome measures (e.g. comfort and goal achievement), feedback, complaints as well as other indicators such as waiting times, proportion of definitive treatments at first appointment, return rates of orthoses etc;

- Encouragement of multidisciplinary working and joint clinics with other specialisms where value can be demonstrated in terms of benefits to patients;
- Appropriately skilled and trained workforce to provide service.

5.13 There was consensus that developing local tariff schemes based on cost and volume rather than block contracts, although challenging, was beneficial in incentivising quality and helped improve data recording and capture to monitor quality improvement. Some of the case studies outlined in this document have successfully implemented cost and volume tariff schemes for orthotics services.

5.14 The CCG and provider case studies described in Section 7 will set out examples of this as well as development of referral protocols, service specifications, KPIs, patient focused outcome measures and other useful information for those CCGs and providers wishing to improve and redesign orthotics services in their local area.

6 Top Tips for Commissioners and Providers

6.1 A number of common elements have been highlighted by the case studies and the stakeholder discussions at the round table event that may provide wider learning to commissioners and providers wishing to review and redesign orthotics services to secure efficiencies and quality improvements for patients.

Engage and Involve Patients and their Families

6.2 They have the best ideas on how the service can be improved and can be involved in a variety of different ways as well as the usual feeding back via patient surveys. By listening to individual service user stories you can truly understand the need for and benefits of orthotic care. For example consider involving them in: informing and shaping the service specification including KPIs and quality requirements; tender shortlisting and interview panels; and forming part of the performance steering groups with the providers of orthotics services.

Include Patient Focused and Outcome Measures / KPIs in Service Specifications

6.3 The case studies presented in this document have provided a number of examples of outcome based quality measures that can be incorporated into service specifications to review and monitor the performance of providers and to ensure the service meets the expectations and needs of patients. These may include the following amongst the many examples:

- Maximum referral to treatment times;
- Orthoses delivery times;
- Orthoses fitting times from initial assessment;
- % right first time;
- Patient outcome measures based on goal attainment scores, for example the proportion of users who report that they have achieved their goals and the percentage of users who report that they are comfortable in their orthoses,

- % of products failed;
- % of patients satisfied with the service;
- Number of patient complaints / compliments received;
- DNA rates

Implement Direct Access Referral for GPs, AHPs, Registered Nurses and consider Self-re-referral for Appropriate Patients

6.4 Direct access referral has been shown in the case studies to improve access for patients and considerably reduce waiting times for assessment and treatment as well as reduce length of stay for in-patients in hospital. Competency based educational packages and training programmes can be implemented to support direct access referral.

6.5 Self-referral can ease and simplify access for those patients who have longer term conditions and are in regular touch with orthotics services and can be supported by clear criteria.

Define Criteria to accommodate the needs of Children and Patients requiring Urgent Treatment

6.6 Urgent appointments and referrals for adults and children (who need a more responsive service and faster turnaround times to allow for growth) should be catered for in service specifications. Examples of urgent criteria may include the following:

- All in-patients;

- Outpatients with the following:

  - ulcerated foot
  - fracture clinic referral for acute injury
  - fracture of spine
  - post botox treatment
  - conditions triaged by clinician as needing ‘urgent’ treatment
  - patients with only one device that has broken and this cannot be repaired by technician
  - recently discharged patients with e.g. hip, spine brace – who are having problems with devices
  - patients requiring HALO vests.

Encourage Adoption of Multidisciplinary Approaches and Ways of Working to Maximise Skills and Efficiency

6.7 The development of a more multidisciplinary approach to the provision of orthotic care, involving appropriately trained AHPs including podiatrists and physiotherapists, registered nurses and multidisciplinary clinics for specific conditions such as diabetes and others has had a positive impact on care for patients. It has helped reduce waiting times for initial assessment as well as speed up in-patient treatment and reduce length of stay, therefore, a multidisciplinary team approach to the provision of orthotic care should be encouraged and considered in the redesign of orthotic services.

Consider Introducing Local Tariffs for Orthotics Services

6.8 As discussed previously, some of the case studies outlined in this document have successfully implemented cost and volume tariff schemes for orthotics services which although challenging, has been successful in incentivising quality and helped improve data recording and capture to monitor quality improvement.

10 Steps towards Effective Commissioning of Orthotics Services

6.9 The following steps are a summary of the key recommendations to commissioners to help improve commissioning of orthotics services:

1. Understand what orthotics care is by talking to patients, carers, managers clinicians and the MDT
2. Examine all of the funding streams your CCG is using to fund orthotic care in your local health economy
3. Unbundle these funding streams to understand the total orthotic investment and consider using a tariff
4. Consider adopting the model service specification (https://www.england.nhs.uk/wp-content/uploads/2015/11/orthcs-serv-spec.docx) which includes patient satisfaction measures, KPIs and includes patient outcomes
5. Clarify the service delivery model you would like to use – for example, retain NHS employed staff (‘in house’) who may use multiple product manufacturers, versus privately employed clinicians who would largely provide their employers’ own products
6. Think about the location - patients generally prefer a non-hospital setting with free parking close to the service
7. Promote access and choice – can you offer near-to-home clinics from local health centres, community venues, day services or special schools?
8. Encourage multidisciplinary working by commissioning multi-disciplinary pathways for specific conditions such as diabetic foot clinics and orthopaedic clinics
9. Look at case studies to inform the most appropriate commissioning model for your area.
10. Involve service users in performance reviews of the service.

7 Clinical Commissioning Group and Provider Case Studies

7.1 Orthotics services are generally funded by CCGs, with some specialised commissioning occurring for patients with highly complex needs requiring specialised pathways of care, for example, spinal surgery, orthopaedics, paediatric neurology and specialised rehabilitation.

7.2 More than 70% of NHS funded services are provided by private companies[1] and a variety of service models exist. The in-house model uses NHS employed orthotists. These staff may have the freedom to use any product supplier or may have to procure the bulk of their product via a specified supplier who wins a product-supply contract. Other services are operated by privately employed orthotists who work for a particular company and who are expected to order products for their patients from that company.

7.3 There seems to be a general consensus that service models for orthotics should be focused on delivering individually prescribed solutions tailored to patient needs and should not rely on a "commodity product procurement" model[8]. In addition and in line with current Government policy**Error! Bookmark not defined.** [26] locally commissioned services should be based on outcomes and monitored on achievement of these rather than inputs[8]. The case studies presented here illustrate some examples of how this is being achieved to improve patient care and provide value to the NHS.

North Staffordshire CCG and Stoke on Trent CCG – Redesign of Orthotics Service

Overview

7.4 North Staffordshire CCG alongside Stoke on Trent CCG and in conjunction with The Orthotics Campaign (which was previously the North Staffs Orthotics Campaign (NSOC)), has completely redesigned the orthotics service locally which sees approximately 5000 adults and children a year. Historically, the orthotics service in Northern Staffordshire was provided by two separate organisations which was confusing for patients and carers. There were also long waiting times amongst other concerns and complaints. An external review in 2011 identified over 150 recommendations for improvement with the main one being that the service should be delivered by one provider. Since then there has been significant service user and carer involvement in the redesign of services and the re-tendering process and the newly commissioned service was contracted out earlier this year to one private provider which provides a hub and spoke model of care.

Developing a Service User and Outcome Based Service Specification

7.5 The overall aim of redesigning the orthotic service was to take account of the needs of patients as a priority and improve the service within existing budgets. The intention was for the redesigned service to deliver the following improvements:

- Better quality of life for patients and carers;
- Delivery of better information to patients and carers to help manage their own conditions;
- Better physical access to services;
- A service that offered equal access to anyone that needed it in the area;

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[26] Department of Health, 2014: The NHS Outcomes Framework 2015/16

- To invest in the prevention of deformity to avoid or delay, and where possible, surgical intervention.

Outcome and Quality Measures

7.6 The service specification includes a number of outcome and quality measures that were felt to be priorities for patients and carers. These include measures such as: time to first outpatient appointment; advanced booking of appointments for fitting whilst patients are in clinic; clear and standardised orthoses delivery times; bi annual patient satisfaction surveys; patient reported outcome measures taken from goal attainment scores (measuring before and after for improvement in function, improvement in ability to carry out day to day tasks, patient perception of the difference the orthotic device has made and improvement in gait); and the availability of clear information and advice in both written and verbal form. More detail on the key elements of the service specification that were felt to be crucial in the delivery of a quality orthotics service can be found at (https://www.england.nhs.uk/wp-content/uploads/2015/11/orthcs-rep-attach-2.pdf).

7.7 The outcome and quality measures form the basis of a monthly core data set which is listed below and used to monitor the contract and performance of the provider:

- % of patients satisfied with the service,
- Number of patient complaints / compliments received,
- Service users/carers receive information about their orthoses including leaflets and information on how to care for their orthoses,
- The proportion of users who report that they have achieved their goals,
- Percentage of users who report that they are comfortable in their orthoses,
- Do Not Attend (DNA) rate,
- Numbers of clinics cancelled and reasons,
- Cancellation rate (by the provider).

Moving from a Block Contract to Local Tariff

7.8 There were significant challenges associated with the proposed move from block contract to cost and volume tariff resulting from the lack of a national tariff and accurate reference costs, as well as the absence of an accurate clinical information system and orthotics ordering system locally, which led to unreliable and infrequent data being presented. The CCGs decided that this approach would be beneficial as a lever to drive and incentivise the quality and performance requirements within the contract which can be at times restricted through the use of block funding arrangements. To overcome the issues faced, a cost and volume arrangement has been agreed with the provider based on one fixed price and inclusive of all costs, with a risk share arrangement in place to cover growth or any decrease in demand to give a level of protection to both commissioner and provider.

7.9 The CCGs have acknowledged that within the first year, this will be a risk for commissioners due to the lack of historic information to allow accurate understanding of the numbers of patients across Northern Staffordshire who will be utilising the service. However, they are confident this model of service delivery will improve outcomes for patients and in turn reduce the demand for high cost surgery for patients in whom orthoses should have prevented their condition from progressing to a level where surgical intervention is required.

7.10 Since the introduction of the redesigned service, early feedback from patients and monitoring of performance is encouraging with signs of improvement in access, patient outcomes and reducing costs. For example, performance is currently running at 60% over activity due to the clearance of a backlog and reduction in waiting times, whilst cost savings are projected to be approximately £300, 000 within this financial year against the historical block contract value across both CCGs. This continues to be monitored on a month by month basis alongside all quality and performance indicators.

Medway CCG and Medway NHS Foundation Trust – Improving Patient Pathways for Orthotic Services

Overview

7.11 The orthotics service provided by Medway NHS Foundation Trust consists of externally contracted orthotists. The service treats adults only from the age of 16 years onwards and treats between 14, 000 to over 18, 000 patients a year. The service has been recognised as a centre of excellence in the South East and was awarded this status in 2010 for its training and innovation and in the way it delivered timely treatments to patients.

7.12 Historically pre-2007, the service used to be provided as part of consultant led elective pathways only. This meant that patients had to be referred to a consultant to gain access to treatment whether the consultant added any clinical value or not to the patient pathway. This led to unacceptable waiting times for patients who generally had to wait at least 16 weeks to see a hospital consultant before reaching the assessment and definitive treatment stage within the orthotics service. It also wasted valuable consultant clinic time. In addition, there was no opportunity for primary or community care services to refer directly as part of the treatment package they could potentially offer to patients. This also led to issues with tariff payments in that the only tariff payable for orthotics were those tariffs attracted by the consultant input either through outpatients or any treatment pathway. A large proportion of patients prescribed an orthotic will require this to be renewed or replaced for the rest of their life and as the tariff only applied to consultant input there was no further payment for this orthotics activity, as often there was no further consultant input to the patient.

Developing Direct Access Pathways for Primary Care and Community Services

7.13 During 2012/13 Medway CCG, Medway NHS Foundation Trust and Medway Community Healthcare worked together to develop direct access pathways for primary care and relevant community services. This involved significant process mapping of existing and potential referral pathways to see where improvements could be made and analysis of referral and activity data which found that around £114K was being needlessly invested in outpatients appointments. A business case outlining the benefits to patients and the NHS organisations involved was approved and a service specification produced to describe the new referral and direct access pathways and the tariff arrangements depending upon the route of referral. (https://www.england.nhs.uk/wp-content/uploads/2015/11/orthcs-rep-attach-3.pdf).

Locally Defined Outcomes

7.14 The outcomes defined in the service specification include the following:

- Improve timely and appropriate access to orthotics,
- Enable direct access to orthotics for primary and community services,
- Reduce unnecessary delay to patients caused by a tariff driven pathway rather than patient outcome pathway,
- Clearly defined and accounted for funding streams,
- Reduce the amount of unnecessary secondary care and community referrals,
- Reduce the amount of unnecessary consultant outpatient appointments,
- Deliver an easy to navigate pathway in line with national and NICE guidance.

The Direct Access and Referral Pathways

7.15 Five pathways are described in the service specification, which are the:

- Community Allied Health Professionals (AHP) Direct Access Pathway
- GP Direct Access Pathway
- Consultant Treatment Pathway
- Consultant Treatment or Diagnosis Pathway with concurrent orthotic input
- Consultant Assessment and Diagnosis Pathway

https://www.england.nhs.uk/wp-content/uploads/2015/11/orthcs-rep-attach-4.pdf

Locally Agreed Tariffs for Direct Access

7.16 Local tariffs for direct access have been agreed and cover 53 orthotics descriptors categorised into 3 bands. More detail on these can be found at https://www.england.nhs.uk/wp-content/uploads/2015/11/orthcs-rep-attach-5.pdf

7.17 The new direct access pathways have cut out around 20 stages in the referral process and resulted in marked improvement in waiting times, being reduced by 15 weeks. Currently, average referral to treatment times for orthotics are between 1 to 3 days.

Quality Initiatives and KPIs

7.18 In addition to improved access and referral pathways, the orthotics service at Medway NHS Foundation Trust has also worked on a number of other areas to improve the quality of the service and reduce costs. For example, it has a workshop on site and can offer some patients a one-stop-shop service. This means that an assessment, plan, implementation and evaluation system can be achieved within a single appointment. It has also specified expected average treatment times for assessment and fitting of various orthoses which help maximise clinic appointments and ward based work. These are listed at (https://www.england.nhs.uk/wp-content/uploads/2015/11/orthcs-rep-attach-6.pdf).

7.19 Clinical evaluation of orthotics products takes place to ensure patients receive the most appropriate treatment to suit their clinical requirements. A scoring template is used by staff to rate different products in a number of areas along with reviewing outcomes such as product fails. (https://www.england.nhs.uk/wp-content/uploads/2015/11/orthcs-rep-attach-7.pdf) These are categorised by patient discomfort, and referring clinicians re-referring patients to the orthotic service if they or the patient feel that the prescribed treatment has not worked by not having an improvement in their condition or their activities of daily living. This process has helped to reduce cost and still use high quality products without compromising patient care. Over an eight year period since 2007, the service has saved over £1million and the average cost per treatment provided has fallen from £63 to £32.

7.20 Finally, the service has adopted a rigorous system for continuously monitoring and improving quality and performance and uses a monthly scorecard consisting of numerous KPIs in categories covering quality, performance, workforce and finance. (https://www.england.nhs.uk/wp-content/uploads/2015/11/orthcs-plstr-photo-scorecrd-2015-16.xlsx)

Nottingham University Hospitals NHS Trust – Modernising the Orthotics Service

Overview

7.21 The orthotics service at Nottingham University Hospitals NHS Trust is provided as an “in-house” NHS service with its own workshop on site. It treats both adults and children across two hospital sites and sees over 14,000 patients a year. Over the last seven years the service has been modernised to improve patient care by improving access and reducing waiting times and reducing costs whilst improving quality.

7.22 Prior to the service redesign, there were substantial staffing, operational and infrastructure issues which left the service struggling to meet the demands of the hospital and patients. This resulted in significant performance problems with long delays in treatment, multiple referral to treatment time breaches and a high level of complaints regarding the inability to access the service in a timely way. Less than 2% of referred patients were issued their orthotic treatment at their first appointment and there was no service specification or KPIs to monitor performance or improvement. Financially, the service was £500K overspent.

Redesigning the Service

7.23 The overall aims of redesigning the service were to:

- Put patient care at the centre of all decisions;
- Improve quality and efficiency;

- Document agreed pathways and policies;
- Develop a new financial structure and processes;
- Implement a new IT system

Improving Patient Access

7.24 A number of initiatives were put in place to improve access and reduce waiting times. This included implementing a triage system for referrals, so that all referrals are triaged by a senior orthotist to ensure urgent patients are seen as quickly as possible. Choose and book direct GP access and referral has been introduced across all sites. Clinic slots for new patient assessments have increased from 20 to 30 minutes as a minimum to allow sufficient time for accurate assessments. Patients with long term conditions that meet specified clinical criteria are able to self – refer back to the service after the initial GP referral. It is estimated this saved approximately 378 GP appointments and the associated costs in 2012/13.

Developing a Multidisciplinary Approach

7.25 Specific multidisciplinary or multi-clinician clinics are held for paediatric patients, diabetes patients, neurology patients, spinal patients and patients with knee and foot orthoses (KAFO). The joint clinics have reduced initial assessment waiting times and allow for patients to be seen at the most appropriate time; the multiple clinicians allow each patient to have a suitable amount of time for their appointment and facilitate learning amongst the clinicians.

7.26 The orthotics service has developed competency based educational packages and training programmes , so that trained physiotherapists and registered nurses can provide specific orthoses in their clinical areas which helps speed up in-patient treatment and reduce length of stay.

Moving from Block Contract to Local Tariff

7.27 A cost and volume tariff has been agreed with commissioners irrelevant of source of referral. Coding for orthotics has been simplified and includes 16 descriptors categorised into four tariff bands which are described in more detail at (https://www.england.nhs.uk/wp-content/uploads/2015/11/orthcs-rep-attach-8.pdf).

Service KPIs, Patient Allowances and Patient Experience Measures

7.28 Key performance indicators are now clearly defined in the service specification and include the following:

- Patient treatment will be given within 18 week RTT pathway,
- All patients to have appointment generated within 5 days of receipt of referral,
- All routine patients to be appointed within 10 weeks of receipt of referral,
- All orthosis to be fitted within 6 weeks of initial assessment,
- All in-patient referrals to have treatment plan initiated within 24 hours of receipt of referral,
- Waiting time for a scheduled Orthotic appointment at the Trust will be kept to a maximum of 30 minutes.

7.29 Patient Allowances are also covered in the service specification and are outlined at (https://www.england.nhs.uk/wp-content/uploads/2015/11/orthcs-rep-attach-9.pdf).

7.30 The orthotic service routinely monitors patient experience measures through patient satisfaction audits, the family and friends test and specific audits such as a foot wear audit and insole pain audit. Patient outcome measures are also used. These include 10m walking test, 3m up and go test and VAS pain scores.

7.31 Overall, these service redesign initiatives have led to substantial improvements in quality and patient experience, as well as reduce costs. For example, paediatric waiting times have reduced from 10 weeks to 2 weeks for an initial assessment and maximum waiting times for fittings have reduced from 8 weeks to 2 weeks. In-patient waiting times have reduced from up to 4 days to the treatment plan being initiated within 24 hours. Over 34% of patients now have their orthotic treatment issued at the first appointment and 98% of patients report a positive benefit from their orthotic treatment with an absence of complaints. Average costs per patients have also been reduced.

Leicester Specialist Mobility Centre – Redesign of Disablement Services Centre

Overview

7.32 Prior to the redesign, the Disablement Service Centre in Leicester was originally commissioned by East Midlands Specialised Services team and services were provided by the University Hospitals of Leicester NHS Trust across three separate hospital sites. The services provided included orthotics, prosthetics, wheelchairs and environmental controls. At the time, the orthotics service was subcontracted to a commercial provider to provide the clinician expertise with a separate contract for product provision, which led to extended waiting times for patients as clinician’s prescriptions were administered by trust staff and orders issued to a variety of stock and bespoke product providers.

7.33 As a result of disinvestment decisions and organisational changes within the NHS, the contract transferred across to the CCGs in Leicester (Leicester City CCG, East Leicestershire & Rutland CCG and West Leicestershire CCG) in 2011, with Leicester City CCG acting as lead commissioner. During this transition, a service review determined that a single provider operating under a fully managed, directly commissioned service would offer all orthotic patients a better quality service. The new provider would employ staff, locate facilities, manage the service and report on patient outcomes. The tender for a directly commissioned service required an experienced provider to deliver an outcome based service under a block contract (equal monthly reimbursements) with the option to move to cost and volume over time. The current service is contracted out to a private provider and has an active caseload of approximately 10,000 orthotics patients.

Key Elements of Service Redesign

Outcome Based Quality Measures

7.34 The new service model is based on a number of outcome based quality measures which require the most efficient model of provision where clinical input and product provision (either produced in-house or procured) are managed together as part of the same process. There is rigorous reporting on the quality measures which are based on the NHS Quality Schedule and include a host of measures such as: infection prevention; patient experience; patient feedback; reporting of complaints and incidents and others (https://www.england.nhs.uk/wp-content/uploads/2015/11/lcstr-orthcs-case-study-temp-qual-sched-rep.xlsx). Specifically for orthotics, a 'right first time' quality measure has been introduced to reflect patient feedback about the historically lengthy process for delivery of orthoses. The % right first time indicator ensures the accuracy of the measurements taken by the orthotists and the manufacture and production enable for the first time right fit. The performance threshold is to ensure 95% or more of patients' orthoses are right first time. Other indicators, such as waiting times, sources of referral and orthotic spend are also monitored. (https://www.england.nhs.uk/wp-content/uploads/2015/11/lcstr-orthcs-case-study-temp-kpi.xlsx).

Flexibility of Location of Service Provision

7.35 The current service has relocated to a fit for purpose, community based facility and aims to meet the needs of patients by providing services in the most suitable setting for them, whether that is at home, school, clinic or in hospital.

7.36 Numerous satellite clinics in community hospitals and special schools cater for the rural community. There are 6 community hospitals and a host of special schools where the orthotists attend on a regular basis. Domiciliary visits are also catered for when the patient is unable to attend any of the clinics. Some of these services are contracted with the provider by a separate contract and paid in addition to the main block contract.

7.37 As the service is no longer located on the hospital sites, a timed ward service caters for the acute hospital's discharge policy. Ward referrals are sent electronically and orthotists will visit the hospital sites daily with the objective of fitting 75% of patients on the day to allow discharge.

Innovative Information Technology (IT)

7.38 There has been significant development in IT systems to enable easier booking of appointments and facilitate patient choice. Electronic patient records can now be accessed by other associated services such as prosthetics, physiotherapy and the wheelchair service and allows greater visibility and access to patient notes by clinicians as they attend satellite clinics.

7.39 The IT system facilitates reporting on all outcome measures and episode of care data and management information which helps to monitor improvements in quality and performance as well as identify accurate information On-going work with the provider is to develop a new process to review volumes of patients, types of patients, referral routes etc. which is important in terms of full validation of data and recognising patient quality and safety and assists the unbundling of funds from block contracts to move towards tariff based systems.

8 Actions agreed at the Round Table Event to Improve Orthotics Services in England

8.1 Commissioners do not currently have all of the tools they need to commission high-quality orthotics services. A number of actions were agreed at the national round table event which have been taken forward.

Agreeing and Developing the Key Elements of a Model Service Specification for Orthotics Services

8.2 North Staffordshire Clinical Commissioning Group has led a process of developing a model service specification for commissioning orthotics services, along with supporting material including key performance indicators. This has taken into account the learning achieved by a number of CCGs and providers. The model service specification is outcomes-based and addresses key issues identified by patient groups. It also addresses how improvement might be achieved step by step. (https://www.england.nhs.uk/wp-content/uploads/2015/11/orthcs-serv-spec.docx).

Improving Data Quality for Orthotics Services

8.3 NHS England will develop a national minimum data set for orthotics services, which will take into account the KPIs from the model service specification. A workshop will be held in November 2015 in partnership with national professional bodies and patient groups to review orthotics data and develop a plan to take forward a national data set.

Workforce Development Issues

8.4 Health Education England (HEE) and NHS England will work together to assess workforce development needs for orthotics service provision, with oversight from HEE’s Allied Health Professional Advisory Group chaired by the Chief Allied Health Professions Officer.

Sharing Good Practice

8.5 NHS England, The Orthotics Campaign and Healthwatch Staffordshire will work together to raise awareness of the variability in quality and highlight the good practice which has been identified to improve the quality of services.

Rehabilitation Framework

8.6 NHS England recognised that the issues affecting the quality of orthotics services are also experienced in other areas of rehabilitation and will ensure that common factors are addressed in future developments.

9 Key Contacts for Case Studies

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Dysphagia Friendly Care Homes: Improving the early identification and management of eating, drinking and swallowing disorders (dysphagia) in 12 North Derbyshire care homes

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Introduction

Care Home support is one of the key values of the strategic plans of the Clinical Commissioning Groups (CCGs) and the National Health Service (NHS). Care Home residents are recognised as one of the most vulnerable groups of service users in terms of health care needs with an estimated 3000 care home residents in Derbyshire having dysphagia (disorders of eating, drinking and swallowing). This project aimed to deliver and evaluate training to all care home staff in 12 selected care homes. The training was designed to increase awareness, knowledge and understanding of dysphagia and how to help.

Background

Poorly managed dysphagia can result in:

- Chest infections and aspiration pneumonia
- Reduced well-being, malnutrition and dehydration
- Morbidity and death with poor end of life care
- Increased dependency and avoidable interventions e.g. General Practitioner (GP) visits, pharmaceutical interventions and admissions to hospital

Timely identification of the symptoms of dysphagia, efficient integrated team work and good care planning are essential in effective management.

Dysphagia is managed by Speech and Language Therapists (SLTs) who have specialised competencies in the assessment and management of eating, drinking and swallowing disorders. SLTs are highly specialised practitioners and demand for Speech and Language Therapy (SLT) services for dysphagia and communication in community and acute hospital settings is high and continuing to grow as demonstrated by increases in referrals to SLT.

The SLT service in Derbyshire Community Health Services NHS Foundation Trust (DCHS) is commissioned to provide a community based service to adults with acquired neurological conditions across the county. The majority of clients are seen within their home setting due to the nature of their health needs. Local hospital in-patients also receive SLT input from our service.

The Adult Community SLT Team in Derbyshire is receiving increasing numbers of referrals to its services year on year, receiving almost 1000 more referrals in the period April 2015 to March 2016 than only 2 years previously.

‘Every £1 invested in low intensity SLT is estimated to generate £2.3 in health care costs savings through avoided cases of chest infections. The economic analysis is likely to underestimate the benefits of SLT which go beyond reduction in chest infections e.g. improved quality of life, avoidance of malnutrition and death. Inclusion of these benefits is likely to increase the net benefit’ (Royal College of Speech & Language Therapists Matrix evidence, 2010).

In 2012, funding provided by The Health Foundation, enabled the SLT service to run a short-term enhanced model of service delivery (SHINE project) focussing on joint working between SLT specialist staff and Nurses with enhanced skills.

A 50% reduction in hospital admissions was achieved in the pilot area in Derbyshire during the project. ‘It is reasonable to estimate that a Care Home could reduce dysphagia related hospital admissions by 1-3 per year where Nurses complete training and fulfil the role as described.’ (SHINE Report, 2012).

In order to provide a sound basis for a larger scale roll out of this model, this pilot project took place in 12 North Derbyshire Care Homes, as detailed below.

Method

An SLT led this pilot project (0.4 whole time equivalent (wte) for 1 month to set up the project, 0.6 wte for 3 months to deliver the training and 0.4 wte for 6 months to provide ongoing support into the Care Homes and analyse the data and report on the outcomes of the project). The project ran from the beginning of May 2016 to the end of February 2017. The Basic Dysphagia Awareness Training session was around 2 and half hours long and was open to all staff in the Care Home who have any involvement with making or serving food and drinks. This included Care Staff, Nurses, Managers, Kitchen Staff, Activity Staff and anyone else working in the Care Home identified as appropriate by the Care Home Manager. All attendees received a pack of handouts to make notes on and to keep for future reference. All attendees completed a pre and post-training questionnaire in order to identify and demonstrate learning from the session. The session followed a set format but was informal and welcoming, encouraging questions and contributions as it went along in order for the session to be relevant to the needs of each group of staff. There were theory and practical sessions on dysphagia itself, oral care, the normal swallow, choking and aspiration risk, thickened drinks, modified diets, successful ways to feed people and case study problem solving.

The learning outcomes were as follows:

- How to identify swallowing difficulties and how to help
- How to prepare appetising food and drink
- How to assist people to eat and drink as safely as possible, and
- How helping people to eat well impacts on health and wellbeing

Following the Basic Dysphagia Awareness session, Nurses who attended the training session and who agreed to go on to become Dysphagia Nurse Champions were given some assignments to complete prior to a tutorial in the Care Home setting a few weeks later. The assignments included a questionnaire measuring how confident the Nurses feel in developing and maintaining good practice within the Care Home team in supporting people with eating and drinking difficulties, Mealtime

Swallowing Observation Checklists to complete, a Care Planning assignment and a Dining Room Observation task. In the tutorial, the assignments were reviewed and further discussion took place around ways to promote good practice within their Care Home. Further resources and information were also given to support them in their role of identifying and supporting basic dysphagia management for all residents, taking a lead role in collaboration with the Speech and Language Therapy Team and promoting good eating and drinking environments. This information could be used to support the Nurses' revalidation process.

Care Homes where at least 60% of the staff attended the Basic Dysphagia Awareness session, and at least 2 Nurses achieved Dysphagia Nurse Champion status, were then eligible to be certified as 'Dysphagia Friendly Settings'.

Outcomes

There are 9 outcomes described below:

1. **SLT referral rates from the pilot Care Homes were measured, both 6 months prior to the project and 6 months after.**

A reduction in referral rate from the 12 pilot Care Homes was identified, see Table 1.

Table 1

Total referrals Dec 2015 - May 2016	**Total referrals Sept 2016 - Feb 2017**
64	59

2. **SLT activity in the pilot Care Homes was measured**

Data shows an increase in SLT activity in the 12 Care Homes in the pilot project. Overall contact time (both face to face and telephone contact) increased even though the referral rate reduced, see Table 2. It is suggested that there are less referrals but perhaps that the referrals are more complex, therefore taking more time to manage. This demonstrates a better use of specialist services and although the activity has remained high this may continue to reduce as the Care Home staff who have been trained embed their skills and need less support from the SLT team.

Table 2

	Dec 2015 - May 2016	**Sept 2016 – Feb 2017**
Pt face to face contacts	**49**	**66**
Pt face to face duration (minutes)	**2790**	**3796**
Phone contacts	**17**	**26**
Phone contact duration (minutes)	**197**	**223**
Total contact count	**71**	**90**
Total contact duration (minutes)	**3047**	**4157**

3. **The number of Dysphagia Nurse Champions per Care Home was measured, see Table 3.**

4. **The number of staff in the targeted Care Homes that were offered and accessed the Basic Dysphagia Awareness training was measured, see Table 3.**

Table 3

Care Home	**Number of staff who attended a Basic Dysphagia Awareness session (and percentage of appropriate staff in that Care Home who attended)**	**Number of Dysphagia Nurse Champions**	**Certified as a Dysphagia Friendly Setting (requires at least 60% attendance and 2 Dysphagia Nurse Champions)**
A	32 (97%)	2	Yes
B	37 (67%)	2	Yes
C	40 (67%)	2	Yes
D	38 (61%)	1	No
E	33 (60%)	4	Yes
F	17 (57%)	2	No
G	19 (54%)	1	No
H	16 (59%)	1	No
I	15 (45%)	0	No
J	23 (46%)	2	No
K	9 (26%)	0	No
L	9 (20%)	0	No
Total	288 (55%)	17	4

5. **Feedback from the targeted Care Homes via structured questionnaire on the impact of the training, including likely outcomes for patients if trained staff had not been available, was collected.**

5 impact questionnaires were returned from Managers of Care Homes that have completed the training. All identified a positive impact following the training on residents, staff, environments and routines in the Care Homes.

The comments are as follows:

‘Some residents have gained weight and residents remain in the dining room for longer’

‘Staff have a greater understanding of food consistencies and viscosity of fluids’

‘Less waste is noted in the kitchen on return of the trolley’

‘Further emphasis appears to be placed on mealtimes than previously.’

‘Our routines and systems have been changed in the Care Home to ensure the high numbers of residents who need assistance are given this. More staff are involved in discussions at handovers, staff are thinking about solutions to concerns raised and making positive suggestions therefore improving the patient experience. Staff have increased confidence.’

‘More adapted cutlery is being offered to our residents by staff. Staff are more positive about the subject and have been heard discussing the training and reflecting on their practice.’

‘In general, staff seem to be more confident in their own abilities and judgement at mealtimes.’

‘Staff have a greater understanding of thickening fluids and they are reporting problems as soon as they are noticed i.e. coughing when eating etc.’

‘There is better utilisation of space in the Care Home, with more able residents eating together in a different dining area meaning that they are eating more and it’s a much more relaxed environment for them.’

‘We are going to try a breakfast café and buffet style teatime to increase residents’ independence and choice.’

‘Staff are using the correct terms for the different diets instead of calling everything just ‘normal’ or ‘soft’.’

‘One of our residents needed syringe feeding before the training, but now with careful observation they can use a nosey cup successfully.’

‘We aren’t having to refer to the Speech and Language Therapy Team nearly as much as we are much more skilled now.’

Also, there have already been enquiries from another 5 Care Homes who would like the training based on feedback from those already involved in the pilot project.

6. **Structured observation of the mealtime environment and patient safety in the targeted Care Homes pre and post training was completed, and feedback from local SLTs working in the targeted care homes was collected.**

Mealtime observations have been completed in all 12 Care Homes.

In those Care Homes who took up the offer of the Dysphagia Nurse Champion training any issues were discussed and addressed in the tutorials.

Post-training mealtime observations were completed in the 4 Care Homes which were certified as Dysphagia Friendly Settings. All these observations demonstrated positive change and evidence that the issues had been addressed by the Dysphagia Nurse Champions.

There was feedback from local SLTs that referrals from the well engaged Care Homes in the pilot project were more appropriate and informative following the training, as follows:

‘The staff nurse I worked with there yesterday was very clear on how to document decisions regarding feeding and issues around capacity.’

‘I saw a person jointly with the Dysphagia Nurse Champion in the Care Home. She was excellent in identifying the cause for concern regarding the patient's swallowing, and was impressive when giving feedback to the relatives. She demonstrated a good knowledge base and a real commitment and enthusiasm with regard to nutrition and swallowing. Her level of care was fantastic. She talked about the dysphagia training that she and the care home have had and she truly was a Dysphagia Champion!’

‘Staff are more clued up and can have informed conversations with me about eating and drinking issues. It’s very pleasing.’

‘At a review both the key worker/carer and the chef took time to speak to me to clarify exactly what the resident could have and how they could modify foods appropriately in order to ensure the resident could have tastes/foods she enjoys, to encourage better and more varied intake. Also, after I had recommended pre-mashed diet for a gentleman, two members of care staff came to the office where I was updating the record in order to clarify how foods should be prepared for this diet. I feel both these examples indicate a positive response from staff to the training they have received and demonstrate an awareness of the importance of following recommendations and promoting good nutritional intake.’

There was however also feedback from local SLTs that showed the need for further training and input in the poorly engaged Care Homes, as follows:

‘Staff there gave her lumpy porridge (not puree) and didn't stick to my advice about staying with her when she is eating "because she's fine.”’

‘The lady was on thickened fluids but declined them gradually and was on normal fluids when I went to review her communication. They did this without any liaison with SLT.’

7. **Pre and post training questionnaires including how staff would identify someone at risk of aspiration/swallowing difficulties and measuring confidence with supporting dysphagia were collected.**

Feedback was obtained following every Basic Dysphagia Awareness session from all the participants on the course.

All staff valued the training and found it useful and comments received were as follows:

‘This training should be mandatory, it’s excellent.’

‘I think every person in care should have dysphagia training as it’s an important part of the job.’

‘The course was very good; I learnt a lot I didn’t already know’

Many participants on the course identified that they had not had this training before and did not previously feel skilled to care for people with dysphagia, despite this being such an important and significant part of their job, as the above comments demonstrate.

‘Now I understand why it’s so important to get the texture of the food right. I never knew any of this before.’

‘I understand the proper stages of thickened fluids now.’

‘It is good to know how the resident might feel and I will be more aware of this.’

‘I really enjoyed the training. It was informative and interactive. I have certainly learnt some things regarding dysphagia and the best way to assist people.’

‘Thank you, your advice and training was very helpful. I will watch for signs of people who struggle to eat and drink.’

Many staff commented that they now understood the importance of observation and communication within their teams, as the above comments demonstrate.

‘I won’t use straws so much, or spouted beakers. I will ensure the correct use of cups and that residents are in the correct position for feeding/assisting with meals.’

‘I will not now give out lidded beakers to all residents.’

Of note was that many participants identified that they had not had this training before and did not previously feel skilled to care for people with dysphagia, despite this being such an important and significant part of their job. Contractually, Care Homes are required to ensure that staff have adequate knowledge and skills to meet the requirements of the job and this is of concern that many staff did not feel equipped to care for people with eating and drinking difficulties prior to the training.

Staff commented that they now understood the importance of observation and communication within their teams and their new knowledge would have a direct and positive impact on the care of their residents by reducing aspiration risk.

8. **Care plans were reviewed both pre and post training in the targeted care homes to see how many residents who needed them had an appropriate management plan in place for any swallowing difficulties/risks.**

An exploratory exercise was completed in all 12 Care Homes to look at the quality of care plans for eating and drinking difficulties.

The style of care plans varied widely between Care Homes.

Some Care Homes had thorough care planning processes and care plans were evidently regularly updated and their relevance ensured, others less so.

One of the poorly engaged Care Homes had two persons’ care plans mixed up and in the same folder meaning that the information for neither person was accessible or available. The same Care Home used folders that were difficult to secure the care plan information into resulting in the care plans falling onto the floor each time the folders were pulled out of the drawer.

The Dysphagia Nurse Champions took on a key role in reviewing care planning within their Care Homes and again, in the well engaged Care Homes with trained Dysphagia Nurse Champions in place, at follow up visits the care plans were observed to be good.

9. **One case study collected to demonstrate a reduction in interventions i.e. avoided hospital admission, reduced GP visits.**

A case example was collected from one of the Care Homes involved in this pilot project, providing a good illustration of the financial cost of unmanaged dysphagia in the Care Home setting, as follows:

The resident has a diagnosis of dementia. The person has had 2 hospital admissions with aspiration pneumonia and 1 hospital admission following a choking episode. They spent 25 days in hospital in total. They also required 6 GP visits in the last 6 months due to chest infections, dehydration and poor oral intake.

With a hospital admission for pneumonia costing up to £7,846, this case example powerfully illustrates the potential cost of unmanaged dysphagia. Other healthcare costs would also have been incurred, for example, GP and primary care visits and interventions, therefore well managed dysphagia represents a significant saving to CCGs.

Of note is that 15% of hospital admissions of people with dementia with dysphagia could be prevented by contributions from an SLT at an earlier point. (Taken from Inpatient Hospital Episode Statistics, Health and Social Care Information Centre, Public Health England, 2015).

This pilot project represents clear value for money by the potential to reduce costly interventions, e.g. hospital admissions, GP and primary care visits.

Recommendations

The success of the pilot project in the well engaged Care Homes was evident. Continued provision of the model was recommended.

The following was the proposed model for managing dysphagia in Derbyshire Care Homes:

Level 3
(Specialist SLT Service):
Patients with the most complex
needs access Specialist SLT assessment

Level 2 (Targeted Service):
Dysphagia Nurse Champions. Each Care Home has at least 2 Dysphagia Nurse Champions to link with SLT and jointly manage symptoms of dysphagia in the Care Home.

Level 1 (Universal Service)
Basic Dysphagia Awareness training for all Care Home staff with every Care Home having a link SLT.

Further details of recommendations were made as follows:

- **Training to be mandatory through contractual agreements, to ensure commitment from the Care Homes.**

  It is evident that the commitment and engagement of the Care Homes is essential for the model to work well. Using contracts to achieve this is recommended.

  When staff didn't arrive for the training as planned in one Care Home, the Manager commented 'Well, It's not mandatory, they don't have to come.'

One particularly poorly engaged Care Home in the pilot project resulted in wasting many hours of the project time available after cancelling 2 planned training sessions at the last minute. There had been concerns raised following the mealtime observation in this Care Home i.e. the failure of the Care Home to refer someone who was choking regularly to SLT, inadequate care planning and Carers showing disrespect to the residents they were feeding by yawning and talking to each other across the dining room. This Care Home, of all those involved in the pilot project needed the training the most, but despite this feedback and the concerns raised, they remained extremely poorly engaged. This not only represented wasted project time, but also placed their residents at significant risk.

- **A band 7 SLT overall lead with a band 5 link SLT in each area.**

This would allow true collaborative working between the Care Home setting and the SLT team.

It would also enable more follow up time to be spent post training and top up training sessions to be delivered as new staff start, for example. Twice a year top up training sessions were suggested.

Ongoing support and maintenance of Dysphagia Nurse Champion competence is also assured with this model via regular access to drop-in sessions with the SLT/Practitioner in the Care Home setting.

- **Care Home Managers to attend the training.**

  Those Care Homes where the Manager has attended the training have shown greater commitment and involvement with the project. It also allows improved continuity of skills and learning as the Manager is aware of the detail of the training that staff have received.

- **Kitchen staff to attend the training.**

  Again, where this has happened there has been greater team working and understanding between Care staff and Kitchen staff, leading to a better overall resident experience.

- **All Care Homes to complete the Mealtime Swallowing Observation Checklist (introduced as part of the training session) prior to making a referral to SLT.**

  This tool ensures that all steps have been taken to address the eating and drinking difficulties in the Care Home setting before an SLT referral is made (and therefore the referral may not be necessary on completion of this tool).

- **The training package is not just suitable for Nursing Homes, but also for Residential Homes using Senior Carers in the role of the Dysphagia Nurse Champion.**

  This has come from feedback from those well engaged Care Homes who also have Residential beds and were keen for their Senior Carers to take on a Champion role too. The title could be changed to ‘Dysphagia Champion’ rather than ‘Dysphagia Nurse Champion’.

Summary and conclusions

‘Eating, drinking and swallowing difficulties have potentially life-threatening consequences. They can result in choking, pneumonia, chest infections, dehydration, malnutrition and weight loss. They can also make taking medication more difficult. Swallowing difficulties can result in avoidable hospital admission and in some cases death. They can also lead to a poorer quality of life for the individual and their family. This may be due to embarrassment and lack of enjoyment of food, which can have profound social consequences. Early identification and management of dysphagia improves quality of life and reduces the possibility of further medical complications and death. Improved nutrition and hydration have a positive impact on physical and mental wellbeing. In addition, there are also economic benefits and savings for the wider health economy, including those through avoided hospital admissions.' (Giving Voice, Royal College of Speech & Language Therapists).

This pilot project in 12 North Derbyshire Care Homes was successful in delivering the following outcomes and demonstrating the following impact:

- **An increase in the number of patients being jointly managed by SLTs and trained staff within Care Homes.** In the well engaged Care Homes there are now strong links with the SLT service to enable future cohesive working in the interests of improved resident experience.

- **Potential avoidance of a proportion of primary care interventions and hospital admissions for dysphagia related problems e.g. aspiration pneumonia.** Care Home Staff have increased awareness of dysphagia and swallowing problems are identified earlier and are dealt with appropriately therefore reducing unmanaged dysphagia which can result in avoidable 'crisis' hospital admissions.

- **An increase in the skill set of the Care Home workforce, enabling differentiation of patients in terms of the level of need and a more cost effective and clinically suitable care pathway.** This improves quality of resident care and experience.

Update

So far it has not been possible to secure funding for the continued roll out of this model and therefore this model has not been adopted in its entirety in Derbyshire care homes. We are able to continue to offer the training package to care homes but have to charge for this in order to be able to fund the Speech and Language Therapy time to deliver it. Outcomes and feedback continue to be excellent and we continue to promote the training package and its benefits.

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Occupational therapy leadership within the Fire Service to reduce fire risk and address health and wellbeing in vulnerable communities

Lauren Walker, Occupational Therapist, Royal College of Occupational Therapists (case study relates to a previous role with Healthy London Partnership)

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Description

An occupational therapist in a leadership role supported London Fire Brigade to implement health and fire-safety focused home visits in 5 diverse London boroughs. The project reached individuals at increased risk of fire and poor health outcomes and took a person-centred approach to identifying health and wellbeing needs, linking service recipients with a range of supportive local services. 90% of recipients reported feeling safer as a result of the service and onward intervention by partner organisations [1].

Context

Project aims and objectives

- Reduce fire risk and improve health and wellbeing for individuals known to be at increased risk – e.g. people aged over 60, those living alone, people with disabilities, people receiving social care services [2]
- Offer advice and person-centred interventions to address targeted health priorities and fire risk factors – falls prevention, cold homes, smoking cessation, social isolation
- Provide occupational therapy leadership for oversight of staff training and competencies; development of strategic relationships between the fire service, health, local authority and voluntary sector partners; and project evaluation
- Develop person-centred assessment, signposting and intervention skills with the fire service's community safety advisors

Baseline data and population demographics

- London Fire Brigade undertake over 80,000 home safety visits each year, providing an opportunity to support a wide range of people at increased risk of harm from fire and health inequalities [3].
- London Fire Brigade operate in all 33 London boroughs, serving an extremely diverse population of approximately 9 million people from a wide range of ethnic and social backgrounds.

- London has the widest health inequalities in England and is home to some of the most deprived communities in the country [4].

Project rationale

- There is a known correlation between people who are at the highest risk of dying as a result of a house fire, and people who have reduced health and experience poor health outcomes [5].
- By supporting people to address their health and wellbeing needs it is possible to also address their fire risk, and vice versa.

Method

Activities undertaken

- 5 London boroughs with diverse ethnic and social demographics were identified to pilot enhanced home fire safety visits, through joint engagement between London's 5 Sustainability and Transformation Partnerships and LFB. The boroughs selected were those where there was felt to be most correlation and prevalence in fire and health risks, and therefore the greatest opportunity for the project to have a beneficial impact.
- Relationships were developed with local health, social care and voluntary organisations to offer pathways supporting falls prevention, fuel poverty, smoking cessation and social isolation.
- Visits were delivered by dedicated London Fire Brigade staff for two years across the 5 boroughs.

Who was involved

- Leadership was provided by an occupational therapist employed by the NHS, working in a project team alongside fire service colleagues.
- The occupational therapist had responsibility for development and delivery of fire service staff training and competencies; development of strategic relationships between the fire service, health, local authority and voluntary sector partners; and project evaluation
- Community safety advisors were recruited specifically to deliver the enhanced home visits and received a range of fire safety and health related training, including Making Every Contact Count [6].
- Over 30 local health, social care, public health and voluntary organisations from the 5 participating boroughs were active members of local strategic working groups for the duration of the project.

Outcomes

Feedback was sought from recipients of the service and project partner organisations, to inform the project evaluation. See *Fire Safe and Well: project summary, learning and outcomes* for full details of methodology, evaluation and outcomes [7]

- 1,253 visits were completed with 1,384 individuals receiving direct advice and intervention
- 80% of visits were completed to households with at least one resident aged 60 or over
- 85% of visits were completed to households with a disabled resident
- 49% of visits were completed to single person households

- 805 referrals were made to partner services offering interventions for falls prevention, fuel poverty, smoking cessation and social isolation
- 99% of service recipients surveyed would recommend the service to friends and family members
- 95% of partner organisations felt participation in the project had been beneficial to their service users
- 90% of service recipients surveyed felt that their safety had increased as a result of the service

Comment from project partner organisation:

“We have had 104 high quality referrals from [community safety advisors] working on the project. These were all vulnerable older residents that our outreach methods had failed to contact. Making these referrals has certainly improved the lives of vulnerable people and, in at least two cases, has probably saved lives.”

Comment from service recipient:

“My daughter is disabled and my husband has memory loss, so I was very impressed with how the fire brigade staff spoke to them clearly and gave excellent advice.”

Key learning points

What worked well

- Occupational therapy leadership was effective in supporting fire service staff to receive training and develop skills that enabled them to apply person-centred approaches when working with at-risk people in their homes, and signposting them to supportive organisations
- Occupational therapy leadership was valuable in developing effective working relationships between the fire service, health, social care, public health and voluntary organisations
- The fire service are able to reach a wide range and large number of individuals who are at increased risk of fire and poor health outcomes.
- Fire service staff are trusted and were successful in linking people who were at risk, but not receiving assistance, with supportive organisations.

Challenges

- The complexity of the health landscape across London made it challenging to adopt a consistent and scalable approach to developing pathways and making onward referrals.

Future opportunities

- Occupational therapists are working in leadership and clinical roles within a number of fire services in England, Scotland and Wales, applying different approaches to embed person-centred assessment and intervention within their organisations’ community safety work.
- Although it was recognised that the demographic profiles of the project boroughs were diverse, closer evaluation of the demographics of home visit recipients would help to identify the impact of enhanced home fire safety visits upon health inequalities and disadvantaged groups. Future projects could be targeted more closely to deprived communities and those at greatest need.

References

[1] [7] Fire Safe and Well: project summary, learning and outcomes – Healthy London Partnership

[2] Health and Social Care Fire Safety Guidance – Greater Manchester Fire and Rescue Service & Manchester Mental Health and Social Care Trust

[3] Home Fire Safety Visits by London Borough – London Fire Brigade

[4] London Health Inequalities Strategy – Greater London Authority

[5] Consensus Statement on Improving Health and Wellbeing between NHS England, Public Health England, Local Government Association, Chief Fire Officers Association and Age UK

[6] Making Every Contact Count – Health Education England

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VISION, VOICE AND PRACTICE

Arts therapy leadership activates creative resources which promote individual, team, and community growth in mental health settings

Nicki Power, Head of Arts Therapies for Bedfordshire & Luton, East London NHS Foundation Trust

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Introduction

The arts therapies include art, dance-movement, drama and music therapy. These four creative professions use non-verbal psychological therapy to support people to make changes in their lives, which can improve both mental and physical wellbeing. The active ingredient in the arts therapies is the art form. Using play and experimentation, the person accessing arts therapies can: explore choices through artwork, trial a different version of themselves in role-play, find their voice with musical improvisation and learn to listen to their physical needs through movement.

While the arts therapies are a specialist and complex intervention[1] in clinical settings, as an allied health profession, arts therapists have a range of transferrable skills which can be activated in leadership roles to support the equally complex agenda of public health.

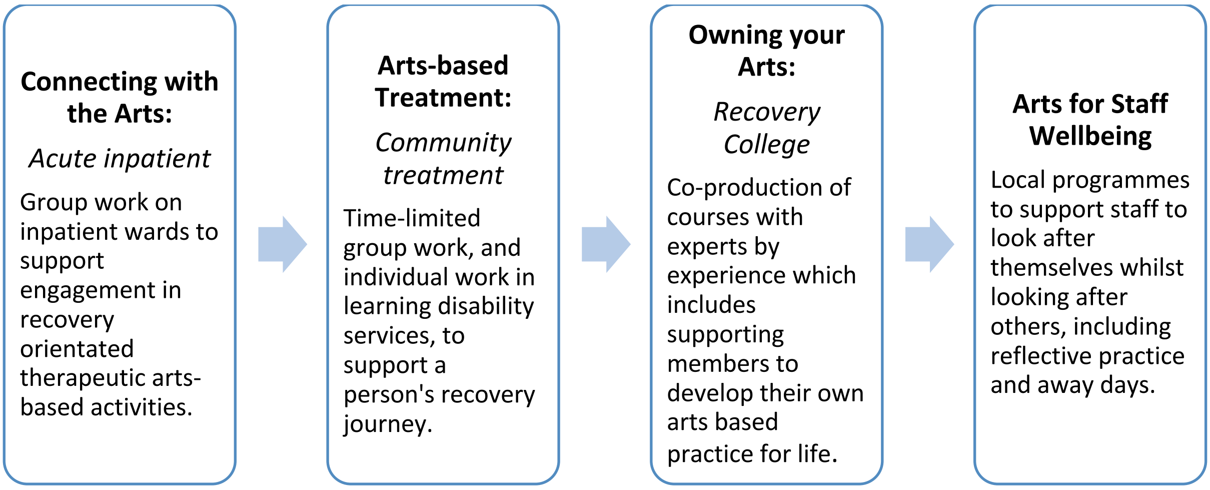
Alongside ensuring that the team deliver effective and timely clinical services in secondary mental health settings, my role as Head of Arts Therapies requires more to reduce local health inequalities in Bedfordshire and to focus on preventative rather than reactionary healthcare. As a leader, I modelled my creative values in action to empower the arts therapies team to do the same. Through collaborative working, we not only maximised our small arts-based resource but built capacity and confidence in other parts of the system with healthcare professionals, experts by experience and local cultural assets.

Context

Bedfordshire has a population of 670,000. As a county it is predominantly rural, with some of the most affluent communities living alongside some of the most deprived areas in the UK. For example, 43% of Luton Borough lies within the top 30% of the most multiply deprived areas in England[2]. Additionally, there is great cultural variety across Bedfordshire, with Luton being one of the most culturally diverse parts of the UK[3]. These geographic and socio-economic factors pose significant challenges for healthcare delivery, but also potential opportunities for celebrating cultural diversity.

The arts therapies team in Bedfordshire and Luton delivers a county-wide service across adult mental health, specialist learning disability and community health services provided by East London NHS Foundation Trust (ELFT). Each of the four arts modalities are represented in our team. However, the arts therapies resource is limited, with the equivalent of four whole time posts serving the entire county.

Under ELFT's Trust-wide arts therapies strategy, clinical interventions are provided across a broad range of services, both inpatient and community, to a varied adult population (figure 1). Locally, we have also included support for NHS staff, both clinical and non-clinical, as an essential part of this arts-based strategy.



Connecting with the Arts:

Acute inpatient

Group work on inpatient wards to support engagement in recovery orientated therapeutic arts-based activities.

Arts-based Treatment:

Community treatment

Time-limited group work, and individual work in learning disability services, to support a person's recovery journey.

Owning your Arts:

Recovery College

Co-production of courses with experts by experience which includes supporting members to develop their own arts based practice for life.

Arts for Staff Wellbeing

Local programmes to support staff to look after themselves whilst looking after others, including reflective practice and away days.

Figure 1: Arts Therapies Service provision in Bedfordshire & Luton, ELFT

This system-wide vision recognises "the benefits that the arts can bring to health and wellbeing"[4] as a recovery tool and in promoting psychological resilience beyond NHS service use. In parallel, our team has sought to provide continuity of care across mental health services so that people can access the arts at any stage of their recovery. To achieve this level of impact several factors drive our work, these are:

- Collaborative working maximises the use of our arts therapies resource which includes transdisciplinary inpatient working and coaching experts by experience to deliver their own recovery college courses.
- Building capacity and confidence in other parts of the system through using arts-based interventions with a strengths-focussed recovery approach for staff, service users and the public creates better outcomes for everyone.
- Clinical service delivery built on quality improvement principles enables a nimble response when providing county-wide services, increasing equity and accessibility, meeting demand in a timely and context sensitive manner. This includes piloting novel interventions in wider teams and introducing group-based delivery in learning disability services.

Arts Therapies working across traditional healthcare barriers

My leadership style is participative, I know that I cannot implement large-scale transformation without my team being active change agents. As a quiet leader[5], listening is essential, in my silence I can hear opportunities for future collaborations and lean-in to difficult conversations, averting potential resistance. To successfully deliver the arts therapies strategy, in line with ELFT's public health priorities, I have prioritised the following:

1. Developing clinical leadership in the arts therapies team

Each member of the team has unique skills and valuable experience, together our creative voice can empower others. Building individual confidence and competence involves working across levels of capability through coaching and supervision, given as part of my leadership role. This included investment in talent through supporting autonomous professional practice and academic development which benefits the team and wider arts therapies. Creative experimentation through solution-focussed learning and working with uncertainty models authentic leadership for the team.

2. Strengthening the current clinical service provision through evidence-based practice

Communication, both verbal and non-verbal, lies at the heart of the arts therapies. Similarly, communication within an organisation is essential in understanding the multifaceted role of the allied health professions.

In our team, we began by holding our service accountable, through producing quarterly reports which included contact data with service users and staff, outcome measures and experience data. This enabled us to meet key targets and to celebrate successes. Additionally, we reduced barriers to accessing the arts therapies through strengthening referral pathways and widening participation across different client groups.

Each arts-based intervention is underpinned by quality improvement methodology, fostering a growth-orientated team culture. Increased visibility for the arts therapies has confirmed our role as valid contributors to multi-disciplinary mental healthcare.

3. Adopting a flexible approach to arts-based interventions to engage a range of stakeholders

Employing our therapeutic and arts-based skills flexibly enables the arts therapies to operate beyond the traditional confines of the clinical therapy room. The arts work across many levels. For example, we can facilitate challenging conversations through metaphor or role play. We can enable diverse groups of professionals and service users to each find a voice and feel heard through creative play. These skills not only provide psychological safety when exploring complex or controversial issues but foster more holistic solutions to issues of organisational change.

Some examples of specific work programmes that the arts therapies team have collaborated on are:

- Service Design

  A transdisciplinary steering group was set up, to develop a radical vision of barrier-free healthcare, for people with persistent physical symptoms and functional syndromes. This necessitated engagement across organisational levels, from borough director to service user. Additionally, we reached across geographic and traditional service barriers to include primary care and other provider organisations across the whole of Bedford Luton Milton Keynes (BLMK) Sustainability and Transformation Partnership (STP).

  An art therapist used a model of visual mapping (figure 2), which enabled all voices to be heard, to distil the strengths in the current system and identify areas for improvement. Through this process discussion of complex areas such as discriminatory language and the psychological impact on clinicians of this work were explored. Visual system mapping accelerated the journey towards personalised care for this client group, through recognition of the strengths in the system and collaboratively designing a better vision.

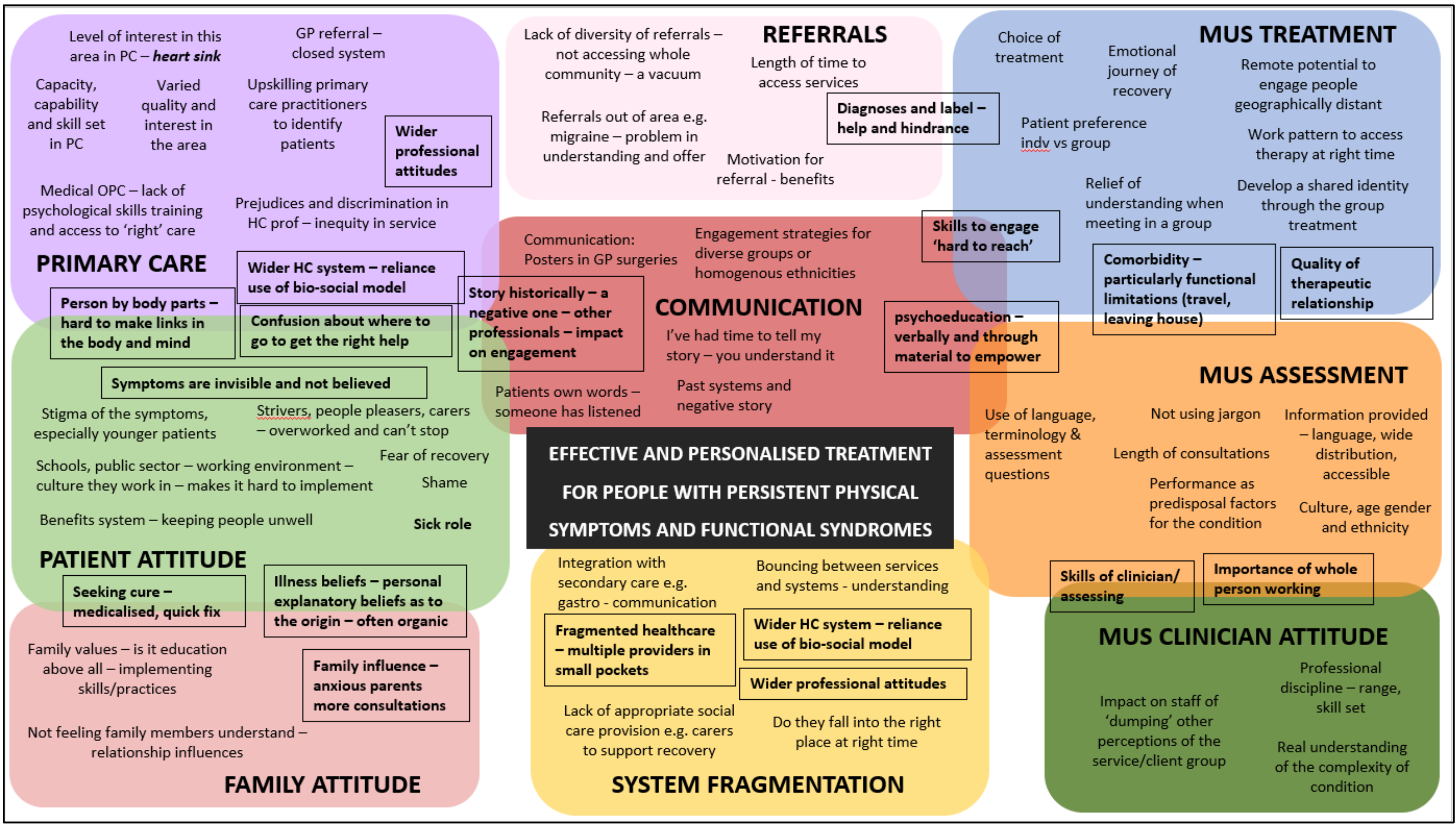


Figure 2: Thematic map of the barriers and facilitators in service access and use
(please note MUS stands for Medically Unexplained Symptoms, this is one term used to describe people who experience persistent physical symptoms and functional syndromes such as Fibromyalgia, Chronic Fatigue or some Musculoskeletal conditions)

- <u>Staff Support</u>

  It is widely known that staff experience is an antecedent to patient experience in healthcare. Teams which are well structured in organisations with a supportive culture, not only achieve higher staff retention and fewer sickness absences but demonstrate reduced patient mortality and readmission rates with increased patient satisfaction[6].

  The arts therapies draw on this evidence when caring for the person in the professional. We recognise the emotional impact of caring work in mental health services. We offer a multi-intervention approach which includes: structured debriefing after critical incidents; contracted arts-based team reflective practice; and during the pandemic tri-weekly creative breakout sessions. Using the arts enables difficult conversations to occur without blame and facilitates a team's own recovery resources through creative expression.

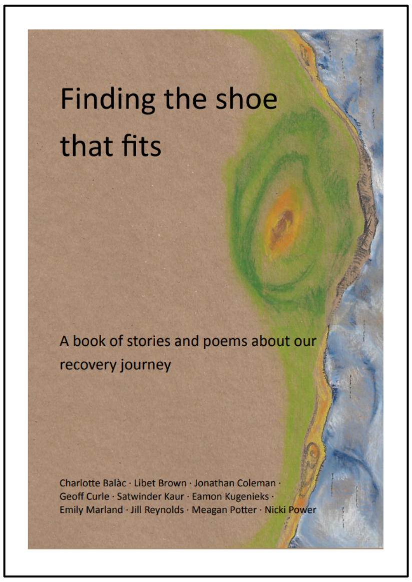
- <u>Strengths-focussed Psychological Support</u>

  People with a learning disability face a range of complexities when seeking support for their physical and mental health. There is a greater likelihood of comorbid diagnoses[7] and communication challenges, alongside referrals originating from support staff not the person themselves[8].

We developed a 4-session arts therapies assessment group[9] to activate service users' personal resources, support them to advocate for their needs and to make an informed choice about accessing psychological therapy. For some, this is all they needed, others enter non-verbal psychological therapy with a greater awareness and motivation to change. In parallel we engage the person's support team to maximise therapeutic success and understanding.

- <u>Recovery College</u>

  The arts therapies wing of the recovery college has seen co-production partnerships between experts by experience, that is, people with lived experience of mental health conditions and arts therapists, grow in unprecedented ways. Following a successful pilot programme with dramatherapy[10], psychoeducational courses are now part of our routine practice. Group members have produced a recovery-focussed book, delivered training within the Trust and presented at national conferences alongside arts therapists. In partnership, the arts therapies and experts by experience have supported local community resources to reduce stigma around mental health, widen access and foster inclusive public environments which promote life-long recovery.



Finding the shoe
that fits

A book of stories and poems about our
recovery journey

Charlotte Balàc · Libet Brown · Jonathan Coleman ·
Geoff Curle · Satwinder Kaur · Eamon Kugenieks ·
Emily Marland · Jill Reynolds · Meagan Potter · Nicki Power

Figure 3: 'Finding the Shoe that Fits' a book about recovery made by experts with experience

Measuring success

There is no single measure of change which can accurately capture the range of interventions which we offer and continue to develop as a team. However, we use triangulation of data from a range of sources to help us build a picture of effectiveness, to identify where the arts therapies add value and to point towards future areas for development. We collect formal outcome measures, experience data and improvement suggestions from service users, staff and carers. Here are some selected outcomes from those who have accessed the arts therapies:

- <u>Arts Therapies Team</u>

  As well as providing direct clinical intervention, members of the team have been supported to write academic papers[11] building the evidence base for arts therapies and to develop leadership skills, for example, becoming a quality improvement coach.

- <u>People who use mental health services</u>

  One person who attended an inpatient group said:

  > *"Do you see how connected people seem now…before the group everyone seemed so isolated and tired…that was such a therapeutic experience".*

  Another person, who attended a recovery college course said:

  > *"Gives you self-confidence to just sing and…*
  > *to go and speak to people with similar health issues".*

  A person with a learning disability who attended individual therapy said:

  > *"I was quite poorly with anxiety and depression… as my therapy progressed,*
  > *I started to feel better in myself, and…I've really enjoyed …my [arts] therapy sessions.*
  > *They've really helped me a lot….I have the tools to help me keep the work up".*

- <u>Staff in ELFT Services across Bedfordshire & Luton</u>

  During the first national lockdown in 2020 the arts therapies team provided arts-based break spaces for 108 staff per month (March to July inclusive). This was a 200% increase in staff support provision. One staff member said they appreciated:

  > *"Having time away from direct clinical responsibility to share …and reconnect".*

- <u>Wider Community in Bedfordshire</u>

  We have created sustainable partnerships with cultural organisations such as the Higgins Museum, The Place Theatre in Bedford and The Hat Factory in Luton. This has enabled people who face stigma to access these cultural settings as equal citizens, and staff beyond mental health care have benefited from mental health first aid workshops.

  Following a film showcase, which was co-produced with young people from CAMHS services (another pilot project we supported), a member of the public who had been in the audience said:

  > *"It was a very unique and special experience …exceedingly informative and deeply moving...immensely powerful voices, speaking and singing of strength and redemption, of emergence and new beginnings. Thank you …for convincing us that a better day is always possible".*

Key learning points

- Creativity is an essential tool in service transformation. The creative process familiar to arts therapists, combined with therapeutic skills of engagement and group facilitation, make us ideal collaborators in complex change programmes.

- Just as arts therapies provide a space apart from everyday life for service users to make changes possible in their lives, this capacity can be harnessed to support staff wellbeing and team building.

- The value of systems approaches in the design and delivery of mental healthcare cannot be underestimated. Interdisciplinary work enables professions with limited resources to reach further and maximise impact. Inclusive mental health services place the lived experience of the people accessing services firmly at the core of practice. Together, we can draw on a range of expertise and build a board skill base to strengthen our whole community's mental health approach.

- True co-production requires professionals to be led by our experts by experience. This takes time and involves learning for all. In any developing therapeutic programme, allied health professionals need to be mindful of the time and energy involved in genuinely collaborative and inclusive working.
- The arts are a vehicle to access the creative potential in the everyday. There is some need for caution when implementing arts-based interventions as part of change programmes. The potential uses of creativity are boundless, this poses a risk that we may over-stretch. Pacing and good project planning can mitigate this risk.

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The added value of art therapy practice within maternity and perinatal parent-infant mental health

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Practice description

Art therapy within maternity and perinatal parent-infant mental health (PPIMH) is a developing area of practice in the UK (Hogan et. al, 2017). This therapy uses artmaking to explore emotional difficulties such as anxiety in pregnancy or postnatal depression. It focuses on improving relationships between parents and their babies up to twenty-four months. A systemic and psychologically dynamic approach ensures a broad therapeutic space for exploring family environments and the deeper transgenerational relationships between parents and their baby's developing personality (Jones, 2019). This model reflects the philosophy of the department where this study was conducted.

Arts in PPIMH features in government reports, such as the Creative Health Inquiry Report (2017) and Arts in Health Evidence-based Interventions (WHO, 2019). The vitality featured in art therapy complements the cultural, socio-economic, and neurological diversity of this demographic. The physical and mental changes that come with pregnancy invite a holistic approach including the arts, mindfulness, and yoga. All have been found to have good economic outcomes for perinatal mental health (Bauer et. al., 2016). The kinesthetic qualities of artmaking (see Elbrecht, 2013) can help subdue emotional and psychological distress resulting from deeply traumatic perinatal experiences. Its sensory methodology helps to regulate attachment transmissions by providing a bi-directional space that encourages bonding and reflective function (Bruce, 2020).

Pandemic context

One in five mothers experience a spectrum of anxiety and depression during the perinatal period (Creative Health Inquiry Report, 2017). A post-pandemic report suggests this figure is now higher (Babiesinlockdown, 2021). The pandemic has also impacted fathers/partners. Women from disadvantaged socio-economic backgrounds are three times more likely to suffer perinatal illness than others in the UK. Black minorities and Asian populations have been most severely affected by the pandemic (Papworth et al., 2021). In 2017, perinatal depression was estimated to represent a long-term cost to UK society of £8.1 billion per annum (Creative Health Inquiry Report, 2017). There has since been an increase in the availability of perinatal services across some parts of the UK, but isolating effects of lockdowns have been particularly stressful for vulnerable women with babies (Papworth et al., 2021). Stigma is a significant barrier to seeking help. It is therefore likely that many perinatal illnesses remain untreated (Broadhurst et al., 2017). Some women are afraid to accept help fearing their baby may be removed from their care or they will be judged as not *good enough* parents (Papworth et al., 2021). Jones aptly uses the phrase ‘*illness of trust*’ (Jones, 2021).

Study context

A six-month art therapy service review was completed within the author’s PPIMH department in 2017. The aim was to help commissioners and professionals understand the benefits of art therapy in this field. Service user feedback was analysed. The findings were later published (Bruce & Hackett, 2020). It is summarised here with a focus on wider determinates and health improvements from including art therapy within perinatal mental health services.

Referrals to the department came from professionals working within the field. The annual referral rate was 1100 at the time of the review. Art therapy was a one-day-per-week service. Referrals were discussed at weekly multi-disciplinary team meetings. Twelve referrals were accepted for art therapy during the review period. Nine led to face-to-face assessments. Presentations included symptoms of anxiety, perinatal depression, posttraumatic stress disorder and self-harming behaviours. Parent-infant bonding issues were predominant. Some women were pregnant, others had babies up to ten months old. Five were from ethnic minorities, four were white British. English was a second language for four women. One used an interpreter. Three families received social care. Five were from low-income, temporary, or overcrowded households. Therapeutic support was offered to fathers. One requested it. Partners were encouraged to attend a father’s group run by the department. Five women received psychiatric services. Seven attended community groups with their babies whilst pursuing art therapy.

Method

Interventions for the nine women and babies took place in the department’s creative therapy room. This was made to feel bright and cheerful. The windows looked out onto green shrubbery. The service also arranged home appointments. Parent-infants were offered weekly ninety-minute sessions. Forty-eight of sixty-eight sessions were attended. This was above average for the department at the time of the review. Intervention length ranged from six-weeks to beyond twelve months. Sessions began with yoga or mindfulness exercises followed by time for artmaking. Art materials were available and could be used freely within the space. The floor was the most common place for activity. This invited mother-baby interaction when a baby was present.

The process of artmaking sometimes aroused memories that reminded women of their own adverse experiences of being parented. This could be a concern, but often generated opportunities for the therapist to help the parent unpack what was recalled, encouraging inter-relational repair and positive moments of mother-baby connection. Session-by-session risk management was paramount in treatment planning. Mothers’ own words were used to describe desired intervention outcomes. Six-weekly reviews helped parents recognise how well they were progressing. This promoted resilience in parenting ability. Interventions were delivered by a fully qualified art therapist with post-graduate qualifications in infant mental health.

Service-user experiences

Two questionnaires were designed to facilitate the service review. These were self-reporting and used to gather views and experiences of the nine women. The British Association of Art Therapists’ research officer was consulted in developing the questionnaires. PPIMHS Strategic & Clinical Lead guided the sensitive quality of the questions for this population. The first included twelve closed questions asking about general experiences of the art therapy service. Answer choices included *very* *true*, *partly true,* or *not true*. The second included ten questions about the women's therapeutic experiences. This aimed to capture moods and feelings recalled from the intervention. A selection of twenty *feeling* words such as *afraid, worried, anxious, relaxed, comfortable,* and *calm* appeared on the sheet. Women could circle words that most accurately matched their feelings before and after the intervention. Room was left for additional comments on each sheet. Eight of nine mothers returned completed questionnaires.

Table 1 highlights the proportion of women who measured *very true* in relation to aspects of their general experience (questionnaire 1). Table 2 highlights the proportion who measured *very true* in relation to aspects of their therapeutic experience. Table 3 highlights the women's most circled *feeling words* in relation to *their* therapeutic experience (questionnaire 2).

No. of mothers	Statements in relation to mothers' general experience of the art therapy service
7/8	I feel that the person who saw me / me and my baby listened to me
7/8	It was easy to talk to the person who saw me / me and my baby
5/8	I have been given enough explanation about how art psychotherapy can help
7/8	The creative art therapy room is comfortable
7/8	The art materials were appropriate
2/8	It is quite easy to get to the place where the appointments are held

Table 1.

No. of mothers	Statements in relation to mothers' therapeutic experience
4/8	Art therapy provides or provided me with an alternative way of communicating.
4/8	During art therapy I felt my mood change for the better following session 1.
3/8	During art therapy I felt my mood change for the better following session 3.
5/8	During art therapy I felt my mood change for the better following session 6.
4/8	The review(s) during the art therapy intervention was/were useful.
6/8	Art therapy is helping or has helped me to understand myself and my problem(s) better.
3/8	Art therapy is helping or has helped me to understand my baby's needs and improve my relationship with my baby.
7/8	The room/environment is helping or has helped me to feel comfortable about sharing my thoughts and feelings.
6/8	The art materials are helping or have helped me to express how I feel.

Table 2.

No. of mothers	Most circled feeling *words from questionnaire 2*
6/8	Before: *worried, anxious, and afraid*
5/6	After: *stable, relaxed, comfortable, and calm*

Table 3.

The results demonstrated that women felt their views and anxieties were considered. Six of eight thought art therapy helped them grasp an understanding of their problems. This ratio suggests that art therapy may offer a generous section of the public a more relaxed way of speaking about their troubles. Half of the women said they appreciated being offered an *alternate way of communicating*. This suggests that art therapy may offer marginalised sectors of the population diverse and inclusive ways to feel valued and understood, particularly if English is not their first language. Feeling understood increases resilience and confidence. This has potential to impact on other aspects of women's lives, for instance in developing creative abilities or pursuing new ways of developing careers balanced with parenting. Half the women experienced positive mood changes following initial sessions. Mood changes may have been influenced by prescribed medication. Three women claimed that art therapy helped them understand their baby's needs. Whilst women didn't always perceive bonding and attachment as a central issue, some said that they did not want to parent their babies in the way that they had been parented. Their drawings reflected this and helped them to see things from their baby's perspective. This can also substantiated by the women's written feedback. Empathy and compassion for others is impactful for society. It can positively affect the health and well-being of future generations. Attendance at parent-infant groups and/or other treatments received concurrent to art therapy could have prejudiced these views. Circumstantial and broader environmental factors may also have influenced change. Samples of women's feedback included:

"drawing gives me memories to put right [in the mother's mind] *and help*[ed]*…me and my baby…it helps me think about my baby's feelings"*

"making things relaxes my anxiety"

"It [art therapy] *jogged me back into thinking 'I can cope without a service'."*

"I looked forward to…art therapy."

These examples suggest women found the art therapy space relaxing. A place where feelings could be held, and anxiety reduced, promoting trust, positivity, and resilience. Women said they felt inspired to find alternative ways to combat anxiety, such as joining craft groups, or spending more time walking in nature. These healthy life-style choices helped one woman become less reliant on services, thus providing an example of reducing wider socio-economic costs.

One woman attended weekly art therapy sessions with her baby over a six-month period. She willingly granted permission to publish her personal story, keen for others to benefit from this approach. Vignette one describes the woman's perception of her background and how this influenced her current mood relating to her baby. The second summarises positive changes gained from the therapy. The final vignette features her responses to a third questionnaire developed to guide an interview approximately six months after the intervention. Vignettes capture her views and experiences of art therapy and the effect this had on her relationship with him. A pseudonym is used here.

Vignette one

In the first months of art therapy, Sandra used drawings to describe how her parents suffered from addiction to alcohol. She was often shut in a bedroom for hours at a time and spoken to in a humiliating and derogatory way. She said, this made her childhood feel frightening and confusing. She described suffering from depression. As a teenager she attempted suicide. Sandra accepted this art therapy intervention shortly after the birth of her fifth baby. She also admitted to suffering depression during previous pregnancies.

The therapist noticed that Sandra hardly looked at her baby during session one. Baby lay quiet and still whilst Sandra spoke of feeling *"lost, isolated and worse than ever before"*. She said how hard it was to feel positive about her baby. Sandra used clay to create the image of a baby (Figure 1).

Figure 1.

Pushing her efforts aside, she said she felt *"useless".* In a different session she scratched an image of herself hidden in a box. The box lay beneath her "*overpowering"* father whose face she *"couldn't think about"*. Sandra appeared unaware of how these memories affected her feelings and prevented her from encouraging her baby to thrive. The therapy enabled her to discuss how she may have unknowingly wanted her baby to feel robbed of affection, like she had felt robbed.

Vignette two

During month three, Sandra began making connections between her images and her childhood suffering. She grew more trusting of the art therapy process. Her confidence increased. She began using whole arm movements to draw across an expanse of paper on the therapy room wall. Sandra created a cohesive visual story of the *"rubbish"* she said was "*suffocating her mind*". She exercised her imagination, creating space to think of how her baby could be stimulated. Their relationship became increasingly animated. She began prioritising his needs. He gradually reached for toys, like Sandra reached to draw with her hands.

Vignette three

During the subsequent interview, Sandra said *"having someone listen and witness my story in a non-judgmental way helped me learn to trust"*. She reflected on images made during the intervention and described how her self-understanding had helped her feel more able to meet her baby's emotional needs. She said this shift came through her hands [kinaesthetic] and through the space available to *"sick out her feelings in art therapy".* She spoke of the "*joy*" she now sought internally and the hope she held for her baby's future.

Outcomes and learning

Research into perinatal parent-infant art therapy is limited (Bruce & Hackett 2020, Hogan et al, 2016). However, this study offers an example of how the cost of perinatal depression to UK society could be reduced. Bauer et al. suggest that increased access to treatment for common maternal mental health problems could provide a net benefit of half a billion pounds (2022). Further studies are needed to examine the reliability and validity of art therapy within this field. Nevertheless, these findings reveal the importance of considering the mental health and well-being of parents and their immediate environment in developing their baby's personality. This innovative approach forms a creative space for parents and babies to thrive together while considering inter-relational repair. This inclusive and diverse approach may also positively contribute to intergenerational health improvements in individuals, communities, and wider society.

As part of the NHS Long Term Plan for perinatal services, the Trust where the review was conducted successfully bid to develop a community maternal mental health service to reach women suffering from posttraumatic stress disorders and perinatal traumas such as sub-fertility, miscarriage, still birth, traumatic birth and loss of a baby through removal by social care (https://www.england.nhs.uk/2021/04/dedicated-mh-services/). Art therapy is being integrated into its forward-looking strategy. This is also reflected in the development of other community teams across England.

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Title: Get Nourished: preventing, identifying and treating malnutrition in older people in Dundee

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Description

This project used five initiatives to prevent and improve the detection and management of malnutrition in older people in Dundee. The project had started in 2019 and it was predicted that the emergence of the COVID-19 pandemic would exacerbate nutritional risk in older people due to restricted access to shopping and a reduction in essential care and support. Restrictions on face-to-face activities required innovative ways of working and partnership with a number of organizations. It has resulted in increased awareness and detection of malnutrition risk, improved access to first line nutritional advice, improved nutritional intake, reduced social isolation and enabled delivery of accessible, consistent nutritional training.

Context

It is estimated that one in ten people over the age of 65 are malnourished or at risk of malnutrition. It is both a cause and consequence of ill-health but is often overlooked[1]. Research has shown that providing timely first line nutritional advice can prevent further disease as well as protect people from falls and frailty and improve recovery time following illness[2].

It was predicted that the COVID-19 pandemic would exacerbate nutritional risk due to limited access to shopping and a reduction in essential care and support[3]. Restrictions on face-to-face activities required innovative ways of working and partnership with a number of organisations.

The aim of this project was to prevent and improve the detection and management of malnutrition in older people in Dundee, while working within the restraints imposed by the COVID-19 pandemic, and consisted of five objectives:

1. To increase awareness and detection of malnutrition risk through use of nutritional screening
2. To increase access to nutritional advice by establishing a telephone advice line
3. To deliver nutritious snacks (Boost Boxes) to people identified as being at risk of malnutrition

4. To provide support to vulnerable people through a weekly meal delivery service and social check in
5. To increase access to standardised nutrition training by developing online training videos

Method

Staff from the NHS Tayside Falls Prevention Team and volunteers from the Royal Voluntary Service were trained to use the Patients Association Nutrition Checklist (PANC)[4] to identify people at risk of malnutrition, give basic advice and signpost to services for further support. PANC was chosen instead of the Malnutrition Universal Screening Tool (MUST) as it is simpler to complete remotely because it does not require measurement of height or weight. PANC has been shown to have moderate agreement with MUST when used to screen for the prevalence of malnutrition risk in older adults in the community[6].

A telephone advice line was established for people concerned about malnutrition risk either in themselves or someone they care for. It was manned by trained healthcare support workers for three hours on three days per week. Additionally, the service could be accessed via a dedicated email account. Information was gathered from individuals using a locally produced, standardised form and they were then provided with first-line nutritional advice and signposted or referred to other services where appropriate. The advice line was publicised using posters in GP surgeries and community pharmacies, social media platforms and emailing multiple partner agencies.

People identified as being at risk of malnutrition either through nutritional screening or after calling the telephone advice line were offered Boost Boxes. These contained 14 high energy/ high protein snacks such as milk puddings, malt loaf, dried fruit and drinking chocolate powder and were designed to provide extra nourishment when appetite was reduced. The content of the boxes was adapted for anyone with special dietary requrements. Trained volunteers from Dundee Volunteer and Voluntary Action delivered the Boost Boxes, reviewed their use weekly and refilled the boxes where appropriate for up to three weeks. Ideas for suitable snacks were discussed if appetite remained reduced after the three-week period, enabling self-management of long term conditions to prevent avoidable admissions to hospital or care homes.

An existing supper club, which had been providing a fortnightly evening meal to 30 diners, was adapted to provide a weekly meal delivery service and social check-in. People who were idenitifed as at risk of social isolation by partners or community members were referred to the Community Development Worker, who would then assess whether the service was appropriate for the individual. Meals were cooked by staff in a local school that had been furloughed and delivered by healthcare support workers. Additionally they received weekly telephone calls to reduce social isolation. Funding for the Boost Boxes and meals was obtained from the Scottish Government Covid Response Fund.

Short training videos were developed and made available on YouTube to address the following topics:

- Signs and symptoms of undernutrition
- Food Fortification
- Nourishing Drinks
- How to fortify your milk
- Get Nourished Advice Line

Outcomes

Feedback from those trained to use the PANC[4] indicated that it was easy to use.

Over a one year period, 70 people called the advice line, with the majority of callers (80%) seeking advice for themselves. On review, 51% of callers reported that they had been able to fully implement the advice provided and 25% had implemented it partially. Twenty-two percent of callers were referred to the Nutrition and Dietetic Service for more specialist support. Almost half of the callers had been signposted to the advice line by the Falls Prevention Team.

Over a one-year period, 48 people were identified as requiring support due to poor appetite and over 150 Boost Boxes were delivered as some required support for longer than three weeks. No referrals to other services were required. Initially there were regular referrals but this decreased over time. Approximately seven people were receiving Boost Boxes at any one time.

Between March and October 2020, over 3000 meals were delivered and over 1600 phone calls were made, providing support, advice and companionship to older people across Dundee. An evaluation survey was issued to 24 households and 16 responses were received. These 24 households were selected as they were within the geographical area of the existing supper club. The survey asked in which ways the service had helped them and the results are shown below.

	Yes	No
I am better nourished	15	1
I am more socially connected to my community	16	0
I am physically healthier	15	1
My mental health has improved	15	1
My general and emotional wellbeing has improved	14	2
I am less lonely	14	2
I feel valued and supported by the community	16	0
My overall morale has improved	16	0

One recipient commented "It has helped me a great deal especially as I have no family nearby. Getting a phone call and knowing where to turn for support is brilliant. I really appreciate everything. I would like to come to the supper club when it starts up again."

Use of videos enabled training and information to be shared quickly, efficiently and consistently. Each video has been viewed approximately 100 times and care home staff reported that they found the one on Food Fortification particularly helpful.

Key learning points

Five partner organisations were involved in this project and it would not have been possible without strong partnership working.

Commented [A1]: Typo: s added to read ‘organisations’

There have been fewer calls to the advice line than expected. This highlights the need for a communication plan to ensure greater awareness of the service. Red flag signs should be agreed to allow identification of those requiring urgent referral to other services.

Many people offered Boost Boxes were given advice to fortify their milk. Therefore, skimmed milk powder was later added to the boxes to make it easier to implement this advice. Some of those referred for a box had often complex and chaotic lives and food insecurity was the main issue rather than poor appetite.   Availability of Boost Boxes needs to be continuously advertised to promote their use.

As restrictions were eased, the supper club was replicated in other areas within Dundee.

As a follow-up to the videos that were developed in-house, a series of professionally produced training videos[6] on preventing, identifying and treating malnutrition have now been developed. These are endorsed by the Care Inspectorate and care providers across Scotland include them within their mandatory training.

This project was undertaken at a time when restrictions imposed by the COVID-19 pandemic necessitated a change in working practices. If circumstances had allowed collection of baseline data and evidence of ecomomic impact, this would have strengthened the outcome data of the project.

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Title : **Orthoptists role in optimising general health - an example of using Making Every Contact Count (MECC) in practice**

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Description

Orthoptists help diagnose and treat patients with eye movement disorders and visual impairment. We interact with patients of all ages, background and ethnicity on a daily basis. Our conversations are not only focused on their eye health but also their general health and well-being. Many patients feel comfortable in expressing other health concerns in clinic as they are already being assessed for eye related issues. This gives an opportunity to start healthy conversations naturally and provide advice as well as signpost to other services if necessary, for example, health care professionals or charities. 'Making every contact count' (MECC) is an approach that many orthoptists use to help improve overall patient satisfaction and outcomes. Informal 'social prescribing' approaches are discussed to show how this can positively impact on the patient's physical and mental health through our consultations.

Context

The aim of this case study is to highlight the role of orthoptists having a positive impact on patients' general health, by exploring the outcomes of MECC in our assessment.

At Stockport NHS Foundation Trust, Orthoptists have been implementing opportunities to 'make every contact' for any patients that are struggling with their vision or eye movement disorders. We are allied health care professionals whose service covers the population of Stockport, meaning we see a variety of both child and adult patients[1]. Consequently, we are able to have appropriate conversations regarding the patients' general health, implemented within the discussions of the appointment. One of the conditions we help to diagnose and monitor is Ocular Myasthenia Gravis (OMG).

OMG is an autoimmune and rare disease which leads to muscle weakness. Often it mimics cranial nerve palsies, gaze palsies and other neurological palsies. It can affect people of all ages, typically occurring more in females than males. Due to the presentation of OMG being incredibly variable[2], it can be a stressful situation for patients as there can be a delay in diagnosis and therefore treatment, if all the relevant information has not been obtained. Often signs and symptoms include, complaints of tiredness, fatigue, eye lid drooping, and double vision[3]. Asking the appropriate questions regarding mental health, smoking, blood pressure, diabetes and substance abuse can assist in coming to a timely diagnosis as well as gauge how their general health may be impacting their overall well-being/mental health. Orthoptists are well suited to identify opportunities as we can have meaningful conversations to provide comfort to patients and improve the overall outcome of their health.

Method

A 36-year-old Gentleman presented with double vision, fatigue, shortness of breath and tiredness in 2019. He was seen in Orthoptics twice and was also followed up in Ophthalmology. In the Orthoptic assessments his symptoms were consistent, however his ocular movements and deviation varied. He was followed up monthly due to the inconsistent presentation. Once the diagnosis of OMG was made, his follow up time was reduced to every few months to watch for the progression.

The Orthoptic assessment was crucial to not only help diagnose but also to assist with the patient's mental health and wellbeing. When symptoms were discussed, he mentioned shortness of breath, which led to an open conversation about smoking and how this may be affecting his health negatively[4]. In the case history of the assessment, he expressed that he felt dizzy due to the double vision, which led to him having falls and incidents at home e.g. pouring hot water over his hand. Consequently, he was given an eye patch to wear due to the unstable nature of his ocular movements, to eliminate the double vision. He was also prescribed steroids by his Neurologist to alleviate his symptoms.

As the patient has Type 2 diabetes, he expressed his concerns regarding his weight gain, which was adding to his recent diagnosis of depression. The patient openly expressed this information, which allowed for an informal 'social prescribing' approach to signpost to Myasthenia charities and other support groups both nationally and locally as required. This shows a positive impact on the patient's mental health in our consultation[5]. All this information was verbally given to the patient, and also written down in the case notes, so that these topics can be raised at each visit to see if any advice was heeded or if any further advice/signposting is required.

Outcomes

The outcomes of this patient are both subjective and objective. The patient's satisfaction at appointments, conversations documented in the records and the improvement of his condition, reveals how our assessments are helping him.

As his double vision was improving, he was given an eye patch to wear at home, in the intermittent instances of the double vision. He felt the patch gave him his independence back by keeping him steady, resulting in less incidents. This helps lower the risk of admission to other pressurised services such as A&E, creating space for other urgent matters.

He was referred to the Eye Care Liaison Officer (ECLO)[6], but also due to his diabetes, the Orthoptist advised him on healthy eating and living[7]. After this, he was more aware of how making better choices lowers vascular risk factors, which can positively impact on his mental and physical wellbeing. This was supported by the 5 steps to mental wellbeing[8]. Healthier lifestyle choices can reduce the likelihood of needing healthcare services long-term, reducing the pressure on the NHS.

Furthermore, this case study showed that patients are willing to discuss vulnerable situations with Orthoptists. These conversations can offer support and guidance but ultimately, the choices are theirs to make. The gentleman joined a support group for men dealing with mental health conditions and researched (myaware) MG charities[9], which helped him immensely to not feel isolated. MECC may be cost-effective in the long-term, as the extra support could help prevent future health concerns, possibly reducing frequent use of NHS services.

Unfortunately, there was no staff feedback or satisfaction survey conducted for a measurable patient outcome. Pre-designed questionnaires could measure changes at each visit, to avoid the potential for error based on subjective observations. This can be implemented in the future to help us collect qualitative and quantitative data to support MECC in our role as orthoptists.

Key learning points

It can seem challenging to have these additional conversations regarding a patient's general health in the allotted appointment time, and when the patient may feel they are irrelevant to the specificity of the appointment. However, when worded appropriately, these conversations can lead to improving quality of life. At Stockport NHS Foundation Trust, we have worked on creating 'business cards' and leaflets for a range of general health conditions that can be given out to the relevant patients. These contain information regarding services and charities that the patient can contact should they wish to. This social prescribing approach helps to inform and empower the patient with regards to their wellbeing.

Orthoptists can provide good health care by looking at the impact on the patient as a whole rather than only diagnosing and treating the eye condition, thus offering a patient centred approach. It is important that we continue to raise these issues sensitively with our Orthoptic patients and to share information with others so we can learn through experiences. This case study shows that we can encourage the patient to implement healthy living choices, even if they do not appear to be directly linked with their initial ocular condition, positively affecting the patients' mental and physical health in our routine consultations.

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Submitted as abstract and peer reviewed publication

Title of Abstract

The Impact of a High Intensity User Programme for Frequent Callers to the Northern Ireland Ambulance Service

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Background: The Northern Ireland Ambulance Service Health and Social Care Trust (NIAS HSCT) receives over 20,000 emergency calls per year from a cohort of service users who seek assistance on a frequent basis. The NIAS Complex Case Team (CCT) seeks to address the needs of Frequent Callers (FC) and the subsequent impact this cohort has on service provision (McDonnell et al. 2022). The FC National Network have defined a FC as ‘Anyone over the age of 18 who calls for an emergency ambulance more than 5 times in one month’ (FreCaNN, 2021). It has been reported that ignoring the challenge of inappropriate use of emergency services leads to inefficiencies, poor patient experience and clinically unsafe environments (Smith and McNally, 2014).

The CCT engages with FCs, establishes appropriate care pathways with statutory and voluntary organisations, utilising a multidisciplinary approach, with wide ranging benefits for patients and stakeholders. Since the CCT was formed in 2017, over 1800 people across Northern Ireland (NI) have met the national criteria. Service users who meet this threshold receive a visit from the CCT. A holistic assessment is undertaken and a profile of the individual and underlying reasons for their use of emergency and unscheduled care services is developed. With the person’s written consent, referrals are then made to the most appropriate care services to meet their individual needs.

In 2022, funding was secured from NHS Charities Together for a 15-month project conducted in collaboration with the British Red Cross (BRC). NIAS worked closely with the BRC to provide bespoke, person centred, support for service users through a High Intensity User (HIU) programme called Interact. Using this person-centred approach, services can work together to ensure that the person's core needs are being addressed, at the same time, reducing the demand being placed on the emergency services and unscheduled care services (Smith and McNally, 2014).

Methods:

The Interact HIU programme was delivered by way of intensive support from a dedicated key worker, to assist with complex unmet health and social care needs known to be associated with FCs (Moseley et al, 2024). The BRC project team consisted of one manager and three keyworkers who engaged with 48 FC. Interventions included assistance with attending key appointments, helping the service user reconnect with community services and empowering individuals to take back control of their own health and social care through motivational interviewing techniques. This programme is a first of its kind in NI for this cohort of service users.

Results:

There was an overall reduction in emergency calls made by the cohort from 1242 calls to 557, a decrease of 55.2%. Ambulance resources dispatched decreased from 443 to 148 (66.6%). Fewer FC were transported to an Emergency Department (ED) with numbers falling from 208 to 81, a reduction of 61%. At the end of the project the Net Cost & Improvement Savings per annum (for 48 individuals) was estimated at £1.94 million.

Further to economic benefits to the health and social care trusts, patient reported experience measures (PREM) have shown a ubiquitous improvement to service user health and wellbeing. Whilst cost-effective, the importance of the financial savings pale in comparison to hearing quotes such as; “You have played a huge part in… helping me when I was at my lowest ebb” and “You have turned my life around” (NIAS HSCT Independent Evaluation, 2024). These improvements are a result of a patient focused, de-medicalised, de-criminalized approach, with interventions specifically identified to meet the service users health and social care needs.

Conclusion:

The BRC HIU programme took a person-centred approach to dealing with FC in NI, complimenting the ongoing work of the CCT. Through positive interaction with both service users and colleagues in partner agencies, an ethos of wraparound care was promoted. This patient-centric approach led to improvements in patient's overall health, well-being and life circumstances, with a subsequent reduction in contact with emergency services. There was a reduced demand on both NIAS and the wider system in a time when it is needed more than ever.

The model of care piloted in this process has the potential for immediate scale and spread throughout the NIAS operational area. Considerations are being explored to source a permanently commissioned workstream to ensure this HIU programme becomes business as usual.

Impact: Our work is -

- Sustained - through a reduction in demand, leading to a financial saving and keeping ambulances available in the community.
- Transferable - through positive outcomes across public sectors, not just within NIAS or healthcare.
- Scalable - through its growth from one pilot area into a regional service with positive outcomes in all geographic locations across Northern Ireland.

Funding - Funding for Interact pilot provided by NHS Charities Together

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